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The National Health Service Corps Practice Management Guide Book

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for the National Health Service Corps

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Services Administration
Bureau of Community Health Services
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PRACTICE POLICIES

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INTRODUCTION

Any business needs an established set of written administrative policies and procedures from the onset of operations. Conducting a medical practice is no different. Written procedures are necessary in order to insure that all parties — the applicant, the assignees, the support staff and the patients — have a clear understanding and uniform expectations as to the manner in which the practice's affairs will be managed.

Each medical facility receiving a National Health Service Corps assignee must prepare a number of written documents. These documents cover legal, administrative and health care aspects of your medical practice. Once written, it is helpful to combine these documents into one handbook for easy reference by board members, assignees and staff.

This booklet has been prepared to assist you in the preparation of your administrative policies and procedures and contains the basic data that should be covered. This booklet was prepared under Contract no. HSA 105-74-211 by Family Health Care, Inc. 1910 K. St., N.W. Washington, D.C. 20006.

PRACTICE POLICIES

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MEETING LEGAL REQUIREMENTS

In order to be eligible to participate in the National Health Service Corps (NHSC) program, the sponsoring agency or group must be incorporated as a non-profit health organization prior to the submission of an application. If the application for participation in the NHSC program is not submitted by a state/local public health agency or other public entity, then the applicant should obtain legal counsel in order to file Articles of Incorporation as a non-profit private health organization (See Exhibit 1, Sample Articles of Incorporation and Bylaws, page 6).

What steps should be taken to incorporate as a private/non-profit corporation?

- A meeting should be held of interested community residents. From this group three or four members should be chosen as the officers of the corporation.
- Seek legal advice on your state's requirements for the incorporation of a private/non-profit organization. The attorney consulted should assist your group in drafting the Articles of Incorporation and Bylaws. Bylaws should state the name and purpose of the organization, list its executive officers and their terms of service, stipulate the quorum required for official meetings and the frequency of these meetings, specify the method of recording and filing of minutes and describe the method to be used to declare and fill vacancies on the Executive Board.
- If you have questions about the specific NHSC requirements regarding the Articles of Incorporation, please contact the NHSC Regional Program Consultant.

What are some of the other items which should be discussed with a lawyer and/or accountant?

- How to file for a "letter of determination" with the Internal Revenue Service (IRS Form 1024) for your non-profit corporation tax exempt status.
- How to apply to the Federal Internal Revenue Service for your federal identification number. This number is necessary when depositing and recording payroll taxes such as employee F.I.C.A. and federal withholding tax.
- How to file the annual Statement of Income for tax exempt organizations with the Internal Revenue Service (appropriate Form 990).
- How to apply to your state taxing authority for a state identification number to be used when depositing and recording state unemployment compensation, disability insurance and state withholding tax for the employees.
- What fire and theft insurance is necessary for property owned by the community corporation and how to obtain it.
- What malpractice insurance is needed for the community corporation, and how to obtain it. (Although the NHSC assignees are covered by malpractice claims filed against them, the community corporation should have its own malpractice insurance to cover its staff, exclusive of the NHSC assignee.)
- What type of fidelity bond is necessary for personnel handling financial transactions of the practice, and how to obtain it.

FORMING THE COMMUNITY BOARD

Although the Community Corporation may be comprised of only three or four executive officers, it is advisable to expand the membership of the Executive Board to include an advisory committee of ten to twelve members.

Why is it a good idea to have an advisory committee?

While final decisions on policies governing the medical/dental practice rest with the Executive Board, it is wise to form an advisory committee. This committee can function as a working committee and assist the Executive Board in the development of specific provisions of Board policies. The advisory committee members can also assist in the day-to-day management of the practice, with each committee member being designated to oversee a specific management area.

How do you form an advisory committee?

Advisory committee members should be chosen from the community based upon their demonstrated interest in the development of a medical/dental practice, the expertise they would bring to the committee and their ability to devote time and effort to the management of a successful practice.

Some of the areas of experience and expertise which the committee members should possess are accounting, financial planning, law, health administration and planning, personnel and business management, public relations, and building or architectural design.

Remember - the advisory committee should be a small but dedicated group.

UNDERSTANDING THE MEMORANDUM OF AGREEMENT

This document is an agreement between the National Health Service Corps and the Community Corporation. It identifies the responsibilities and relationships each party assumes in the health service project.

The agreement should be signed by the Community Corporation within 30 days of notification by NHSC that health personnel have been matched to the community. The Memorandum of Agreement becomes effective from the actual date of assignment of health personnel to your community.

What is the purpose of the Memorandum of Agreement?

The Memorandum of Agreement, commonly referred to as the M.O.A., is essentially the understanding reached by both parties, the Community Corporation and the National Health Service Corps, concerning their respective responsibilities to the project. As in any business, it is important for principal parties to

agree in advance on the "ground rules" for the services to be administered and delivered. The M.O.A., then, commits both parties, in writing, to specific areas of responsibility. Since the M.O.A. affects all functions of the practice, the health care staff should also be acquainted with its contents.

Who should be aware of the M.O.A. and its provisions?
It is absolutely essential that the Community Corporation Executive Board and the advisory committee comprehend fully all provisions of the M.O.A. Once the M.O.A. is written and signed, the staff and assignees should review this document and understand its contents. Any new staff members of the health care facility, or new members of the Board should also read it carefully and have an opportunity to discuss its provisions with the Community Coordinator.

DEVELOPING A TABLE OF ORGANIZATION

A table of organization is a chart which reflects the lines of authority and responsibility among the three parties involved in the operation of the practice — the Board, the assignees and the staff.

Why is a table of organization necessary?
One of the first items on the agenda in establishing any business is the design of a table of organization. This table illustrates the relationship each particular function will have to the production of the final product. The end product of a medical practice is the delivery of efficient and effective services to the patient. To this end, a table of organization should be developed that indicates the relationship and lines of authority among the Board, assignees and staff and the responsibilities of each individual in the organization.

How is a table of organization developed?
- The Board defines the lines of authority for the practice in a table of organization. How the table is structured is based upon the budget, the number of providers, support staff and the size of the anticipated patient load.
- The Board and assignees jointly define the lines of responsibility. For instance in a one-provider practice with a moderate sized patient load, the assignee(s) may assume responsibilities that in a larger practice would be delegated to an administrator. It is important that the Board and providers have agreed in advance on the responsibilities they will have. The table of organization should clearly illustrate this agreement so that provider(s), community and staff can easily identify persons responsible for various functions of the practice (See Exhibits 2 and 3, Sample Tables of Organization, pages 16 and 17).

FORMULATING PERSONNEL POLICIES AND PROCEDURES

Personnel policies and procedures are the rules and regulations which govern the employment of all personnel directly hired by the community Board.

Why are written personnel policies and procedures necessary?
A definition of the terms of employment must be clearly understood by each employee prior to accepting a position. The establishment of these terms of employment in writing will also avoid arbitrary and unfair treatment of employees and will set forth the employer's position (See Exhibit 4, Sample Personnel Policies, page 18).

What topics should be included in the written personnel policies and procedures for non-NHSC personnel?
The following are suggested subject areas in which written policies should be developed by the community corporation:

Full-time and Part-time Employment
Full-time employment is usually considered a work week of 35-40 hours. The full-time employee's salary should be established on a monthly or annual basis, with vacations, holidays and other "benefit" days considered as fringe benefits.
Part-time personnel are frequently used on routine schedules or to cover periods of illness or absence by regular full-time personnel. The basic hourly rate paid to the full-time employee should also be paid to the part-time employee in a similar position. Shift differentials are also paid on the same basis. Part-time employees, however, do not usually receive benefit days. Other fringe benefits are usually provided to part-time employees only if part of practice policy, or if required by local, state, or federal legislation.

Hours, Leave of Absence and Vacation
When writing a statement regarding work hours, leaves of absence, and benefit days (vacation, sick time and holidays), consider the standards for the area, practices of competitive employers, professional comparability and cost, and availability of part-time, temporary and seasonal personnel.
Hours: Hours of work should be stated clearly and also recorded on an employee work schedule and time card.
Vacation: The number of days and hours of paid vacation, criteria for eligibility and procedures for use of vacation, days, pay in lieu of vacation, expiration dates, terminal vacation pay, cut-off dates and accumulation rates should be specified.
Sick Leave: Payment for sick days is considered customary. It is important to consider and state the process for the accumulation of paid sick leave credits, dates or periods of eligibility, conditions for use, payment approval, controls, maximum accrual and terminal benefit pay.

Personal Leave: Personal leave is time off other than vacation, holidays or sick days. It is sometimes granted for special circumstances such as a death in the family. State number of personal leave days accrued per year and when it is allowed, along with how and who approves it.
Holidays: State number of days or hours allowed for paid or unpaid holiday time each year; service eligibility; whether these holidays are all on regular scheduled days or varying dates, e.g., special religious holidays; and state length of time in service to earn holiday accrual, accrual schedules, use, postponement, and pay in lieu of holiday time off.

Salaries
Salary schedules should include a scale which indicates the range of rates for each position and a time table for incremental increases.

Example: Registered Nurse
Starting rate $7,294; after six or twelve months $7,658.70; after x months $8,041.53 and accrual increments thereafter to a maximum of $11,500 — contingent upon satisfactory performance.

Salary and wage schedules should be reviewed periodically and adjusted to meet changing economic and financial conditions. The employer and employee should discuss salary, methods of payment, job requirements and criteria for salary increases as part of the preemployment negotiations.

NOTE: Some nonprofessional, nontechnical services such as housekeeping and maintenance are compensated on an hourly or contract rate without consideration for longevity or performance increments.

Fringe Benefits
Fringe benefits are granted by an employer to the employee and involve a money cost to the employer without affecting the wage rates of the employee. It is therefore important that the Community Board take an active part in the decisions related to the fringe benefit package. Fringe benefits should be comparable to those offered by other industries/institutions in the area.
A typical "package" might include: health care plan, life insurance, accident insurance, pension program, and similar benefits provided at no cost to the employee, or at a shared cost by employee and employer, or on a group rate basis. Part-time personnel (less than 50% time) are seldom covered by the total benefit plan of the organization. However, the benefit plan may be provided to an employee who is expected to work more than half the required number of hours of a full-time employee on an annual basis.
Remember - There are several benefits which are determined by law or statute such as unemployment insurance, temporary disability insurance and social security. These are customarily paid in part by the employee and employer. Federal legislation has also been passed that affects pensions of both full-time and part-time employees. Be sure to check the legality of decisions in this area.

Confidentiality of Patient Information
Communication of personal information regarding the patient, client, staff or associate must be regarded as confidential. Patient's medical records, telephone conversations, family history, diseases or illnesses and other matters must *never* be communicated beyond the scope of professional and paraprofessional personnel who require such information to treat the patient. Information regarding the practice, policies, types of cases, internal problems, etc. should not be discussed with family members, personnel of other organizations, news media or the general public except by those individuals who are directed to communicate such information at the appropriate times.
A written policy concerning confidentiality should emphasize that any infringement will be considered a gross violation of rules and may lead to immediate termination.

Probation and Termination
Probation and termination policies are an integral part of the personnel policies. Some factors to be considered in your policy formulation follow:

- ☐ Any new employee is usually considered to be "on probation" during the first 90 calendar days of employment. Sometimes a supervisor will recognize within a short period of time that an employee is not suited to the position or organization. In this case the employee should be terminated with two weeks' notice and the reasons for termination should be discussed with the employee.
- ☐ If an employee commits a gross violation of rules (i.e., discusses confidential medical information), or has been dishonest, he/she is usually discharged immediately, without notice.
- ☐ Termination procedures should be understood by all members of the group, as well as the method for giving notice, the time required for this notice, and the person to whom this notice should be given. Points to be considered are:
  Involuntary Termination: Termination for reasons of poor performance or violations of policies or regulations must be recorded in detail with specific dates and incidents noted. Performance evaluations and disciplinary action reports should be part of the employee's personnel file. Termination records should be completed by the supervisor, stating incidents and actions which led to dismissal. Prior to termination the compilation of the performance evaluation should be discussed with the employee.
  Voluntary Termination: When an employee's plans or personal needs necessitate a change or discontinuance of work, this is considered voluntary termination. NOTE: Determine if the employee's resignation should be covered by a leave of absence, disability leave, etc.

Termination Pay
Pay for hours worked and benefit days due (in accordance with policies), actual days and dates covered in the employee's final check and other monies due or deductions made, must be defined and recorded for

both the employee's and the organization's records. The type of termination and dates of payment influence unemployment insurance benefits and other similar programs. Almost every state has specific requirements for termination pay. These are usually found in regulations published by the wage and hour division of the State Department of Labor. These provisions should be incorporated into the practice's personnel policies to aid your supervisory personnel.

Grievance Procedures
Most businesses have a formal procedure through which employees are encouraged to discuss their differences with the management without fear of retribution. It is considered good employer-employee relations to establish such grievance procedures and have them clearly stated in your personnel policies.

Non-Discrimination
As the sponsor of the NHSC program, a non-discrimination clause must be included in your personnel policies and its contents adhered to. Provisions of this clause are as follows: "The Community Board (sponsor) certifies that it does not now, and assures that it will not in the future, discriminate on the basis of race, creed, sex, color, age, national origin, religious beliefs, physical handicap, marital status, ancestry or liability for service in the Armed Forces of the United States, or have any interest to make any limitation, specification or discrimination, unless based upon a bona fide occupational qualification. The Community Board agrees this provision against discrimination will be carried out by the applicant as the primary contractor or by any subcontractor or other supportive agencies or parties. NHSC personnel will not be used, directly or indirectly, in any situation wherein care is provided in a discriminatory manner. The Community Board will take all action necessary to determine if prohibited discrimination exists, whether directly or indirectly, and will report promptly to the National Health Service Corps any such discrimination. Each unit will provide the National Health Service Corps access to all records and other information deemed necessary by the Corps to ascertain compliance with this Section. The applicant will comply with all federal, state and local laws and regulations regarding employment, wage rate, taxes, disability and unemployment insurance and other programs required by employers in the locale."

What are the Personnel Policies and Procedures for NHSC Personnel/Assignees and U.S. Civil Service Employees?

U.S. Public Health Service Guidelines
The general rules governing the Personnel Policies and Procedures for NHSC assignees can be found in the *USPHS Officers Handbook* which can be obtained from your NHSC Regional Office.

NHSC Guidelines
Each NHSC assignee is expected to adhere to the specific Personnel Policies and Procedures as established by the Director of the National Health Service Corps. To ascertain the specific administrative personnel policies governing NHSC assignees, contact the NHSC Regional Program Consultant in your region.

U.S. Civil Service Employee Guidelines
If a member of your staff is a U.S. Civil Service employee (as opposed to a Commissioned Officer in the U.S. Public Health Service), there are specific personnel policies and procedures which are applicable to him/her. Once again, your NHSC Regional Program Consultant will assist you in obtaining the information needed in understanding the terms of employment governing U.S. Civil Servants.

DEVELOPING PRINCIPLES OF PRACTICE

Principles of Practice define in writing the range and scope of the health care delivery in a practice. In addition, it serves as a set of *operational guidelines* to be followed that will assist you in reaching your practice goals and objectives.

Why are Principles of Practice necessary?
Principles of Practice give everyone associated with the practice—patients, providers, Community Board, staff — a clear understanding of the health care goals of the practice as well as guidelines for day-to-day operation.

How do you develop a Principles of Practice?
The Board management and provider(s) should jointly develop this document with some input from staff. The Board and management may jointly decide those policies which relate to the day-to-day operations of the office. The professional staff should participate in the policy development relative to the management of patients in the practice.
There are two broad areas of decision making:
Practice Management
Patient Management

Practice Management
These are functions of the practice that indirectly affect the care of the patient and usually center on the administrative procedures of the practice. These areas may be defined jointly with the participation of the providers, Community Board, and management. They are:

Group objectives
- **The method of reimbursement**
- **The target area to be covered**
- **The goals of the group**
- **The kind of service (episodic, emergency, comprehensive)**
- **The goals in community health (if any)**

Hours, Scheduling and Coverage
- **The schedule of office hours**
- **The schedule of office hours for emergencies**
- **How the practice will be covered during unscheduled hours:**
  Telephone coverage
  Referrals
  Physicians on call
  Answering service
  House calls (determine when and if they will be done)
  Facilities available for emergency care and when they are to be used
- **When patients are to be:**
  Referred
  Seen immediately

Seen the same day
Seen when convenient

Fee Schedule
- **What the fee schedule will be**
- **How the income will be disbursed**
- **How the medically indigent will be handled regarding payment of fees**
- **What the policy will be for fee collection and billing**
- **What the policy will be for collecting delinquent accounts**

These should be in accordance with any NHSC policies and with approval of the Regional Program Consultant.

Staff Responsibilities
- **Written job descriptions**
- **Schedule of staff meetings**
  Entire staff
  Physicians only
  Board and staff

Education
- **The time required away from the practice for the providers and health professionals on continuing education programs**
- **The physicians' responsibility for the training of non-physicians**
- **The type and form of community education programs that will be conducted:**
  Pamphlets
  Seminars
  Patient access to chart information
- **Management Information System**
- **Professional Courtesy Policy**
- **Special Data Needs for Community Health Planning**
- **Grievance Procedures**
  Board
  Physicians
  Staff
  Patients
- **Schedule of Board/Provider Meetings During a One-Year Period**

Patient Management

These are functions of the practice that directly affect the care that is provided for patients. These areas are usually defined by the medical staff of the practice. They include:

Patient care
- **Comprehensive physicals**
  Definition of when and for whom comprehensive physicals will be required.
  Definition of minimum data which will be collected on each patient by age and sex.
  Definition of when interval repeat checkup will be required by age and sex.
- **Acute care**
  Definition of data base needed in acute care.
  Designation of staff members who will perform each part of the examination and treatment.
- **Chronic care**
  Definition of specific data base needed for each disease.
  Designation of staff member who will provide continuing care and under what circumstances.
- **Coverage**
  Make a list available to the receptionist of the following referral services if they are not services of your medical practice.
  Ophthalmology
  Dentistry
  Neurology
  Neurosurgery
  Psychiatry
  Orthopedics
  General surgery
  Obstetrics
  Gynecology
  Minor surgery

Hospitalization, Consultation and Referrals
- **Who will be hospitalized**
- **Where patients will be hospitalized for:**
  Obstetrics
  General Medical Problems
  Surgery
  Special surgery, i.e., open heart, neurosurgery, etc.
- **How referrals for hospitalization will be made**
- **How findings from hospitalizations will be returned to the practice**
- **How findings from consultations will be returned to the practice**
- **What lab work will be done in your practice**
- **What lab work will be referred out and where**
- **What X-ray work will be done in your practice**
- **What X-ray work will be referred out and where**

Audit
- **The procedural audit of the medical record (what atandard information recording procedures will be checked)**
- **The performance audit of the staff (what and how performances will be checked)**
- **The peer audit of the provider (what and how patient care will be checked by other physicians)**

SETTING UP OTHER DOCUMENTS

Personnel Records

The personnel records of employees should begin with the health records, application for employment, copies of the salary agreement and insurance forms. Pay increase notices, vacation and benefit day requests, evaluations, disciplinary actions and commendations should be added. The records of the employee are confidential. Personnel records should be retired and retained in a storage area for whatever period of time required by your state. No information should be copied or removed without the employee's knowledge.

Fire and Safety Program

The Community Board is responsible for the establishment and maintenance of an effective fire prevention and safety program, and for the maintenance of current and accurate information regarding the provisions which affect the center as contained in the Occupational Safety and Health Act of 1970. For further information on this Act contact your local state Department of Labor.

Fire prevention programs should be developed, written and posted in a prominent place. Each employee's orientation should include training in location and use of fire extinguishers and fire hoses.

Safety programs should be established and information on proper use of equipment explained not only during orientation, but periodically, as new equipment is received and activated.

EXHIBIT 1

SAMPLE ARTICLES OF INCORPORATION AND BY-LAWS FOR AN NHSC SITE

STATE OF ALABAMA

COLBERT COUNTY

TO THE HONORABLE JOHN B. SOCKWELL, JUDGE OF PROBATE IN AND FOR SAID COUNTY:

We, the undersigned members of the Cherokee Lions Club, Cherokee, Colbert County, Alabama, desiring to make a health clinic, which the said Cherokee Lions Club has sponsored during its organizational stage, a body of corporate under the laws of the State of Alabama do make and file the following certificate:

1.

The name of the corporation is WEST COLBERT HEALTH CLINIC, INC. .

2.

The objects for which this corporation is formed are exclusively, purely and strictly benevolent, charitable, for the relief of human suffering, for the benefit of mankind, the promotion of the health of mankind, and not for financial gain, and no financial gain shall ever accrue to any member of the corporation, not any person or institution in the conduct of same, no part of the net earnings shall inure to the benefit of any private sharekeeper or individual, and no part of the activities of which shall be carrying on propaganda, or otherwise attempting to influence legislation, but any receipts of this corporation in excess of the expense of purchase, or erection and maintenance of said clinic, shall be applied by the trustee-directors to the care of charity patients, and to the equipment and enlargement of said clinic, to carry out the objects of its organization and operation, as they in their judgement deem wise. It is organized to acquire or erect, and to equip, conduct, repair and maintain, on the broadest humanitarian principles a health clinic, and training school for nurses, to care for the sick and injured, to accept donations, in either property or money, and to educate and train persons in the care of the sick and injured, issuing to each person diplomas upon graduation, and erecting and conducting such clinic and school.

3.

The location of said corporation's principal office shall be in Colbert County, State of Alabama.

4.

The corporation shall be non-stock and no dividends or pecuniary profits shall be declared to the members thereof.

5.

The corporation shall have perpetual existence.

6.

The amount of capital with which the corporation will begin business will not be less than two thousand dollars ($2,000.00).

7.

Consistent with the purposes and objects of the corporation, the following undersigned members of the Cherokee Lions Club, shall be the original trustee-directors, and shall be empowered to adopt rules, regulations and by-laws of the execution of the corporation powers herein stated, and shall serve a term of years as trustee-directors as indicated by that term which follows their name:

G. W. Perkins, Chairman, for a term of 6 years; Herbert Harris, Jr., for a term of 6 years; Curtis Hester for a term of 4 years; Malcolm R. Turberville for a term of 2 years; and C. H. Stutts for a term of 2 years. Their terms shall run from the date which this certificate bears date.

At the conclusion of each of the above terms the Cherokee Lions Club shall elect trustee-directors for terms of 6 years each. In the event the Cherokee Lions Club declines to elect trustee-directors or in the event the Cherokee Lions Club, as presently constituted and organized, goes out of existence then the trustee-directors shall be elected by the then constituted board of trustee-directors at least a month before the term of office will expire.

8.

The trustee-directors assume no personal liability in any manner as to any contractual or tort liability which may be assessed against this clinic.

IN WITNESS THEREOF, we have hereunto set our hands and seals, this 14th day of July, 1949.

(s) Harvey A. Ligon (seal)

(s) T. J. Wilson (seal)

(s) Leslie Malone (seal)

(s) Hubert L. Hargett (seal)

(s) V. T. Paden (seal)

(s) Will Yarbrough (seal)

(s) W. W. Hester (seal)

(s) J. R. Malone (seal)

(s) J. H. Christopher (seal)

(s) Ralph H. Woodington (seal)

(s) G.W.Perkins (seal)
G. W. Perkins

(s) Herbert Harris Jr. (seal)
Herbert Harris Jr.

(s) Curtis Hester (seal)
Curtis Hester

(s) Malcolm Turberville (seal)
Malcolm Turberville

(s) C.H. Stutts (seal)
C.H. Stutts

A RESOLUTION

WHEREAS, The Cherokee Lions Club, Cherokee, Alabama desires to establish, erect, and maintain a health clinic for the residents of West Colbert County, State of Alabama, and to incorporate this health clinic, and to obtain federal and state aid in the establishment, erection and maintenance of said clinic;

WHEREAS, The Cherokee Lions Club is in a duly convened assembly in Cherokee, Alabama on July 14, 1949;

BE IT THEREFORE RESOLVED, That the Cherokee Lions Club petition the Judge of Probate of Colbert County, Alabama to make this health clinic a body corporate under the provisions of the Code of Alabama, 1949, Title 10, Section 124 and 150; that the business of said clinic be conducted by a Board of Trustee-Directors which originally shall be composed of G. W. Perkins, who shall serve for a term of 6 years; Herbert Harris, Jr., who shall serve for a term of 6 years, Curtis Hester, who shall serve for a term of 4 years, Malcolm R. Turberville, who shall serve for a term of 2 years, and C. H. Stutts, who shall serve for a term of 2 years. At the conclusion of the terms of each of the individuals named above as Trustee-Directors the Cherokee Lions Club shall elect Trustee-Directors for regular terms of 6 years each. In the event the Cherokee Lions Club, as presently constituted and organized, goes out of existence then the Trustee-Directors shall be elected by the then constituted Board of Trustee-Directors at least a month before the term of office shall expire.

Be it further resolved that no member of the Board of Trustee-Directors or of the Cherokee Lions Club assume any personal liability in connection with this clinic; and that any formal resolutions or motions which have been adopted in connection with any of the provisions of this resolution are hereby revoked.

STATE OF ALAMAMA
COLBERT COUNTY

I certify this resolution to be a true and correct copy of the resolution adopted by the Cherokee Lions Club on July 14, 1949.

(s) G. W. Perkins
as President, Cherokee Lions Club.

Subscribed and sworn to before me this 15 day of July, 1949.

(s) Howell Thos. Heflin
Notary Public

(notary seal)

BY-LAWS OF
WEST COLBERT HEALTH CLINIC, INC.

ARTICLE I.

Section 1. The West Colbert Health Clinic, Incorporated, may be hereinafter referred to as the clinic.

Section 2. The purposes for which this clinic is formed are:

(a) To facilitate, assist and participate in, together with the State Board of Health, or other designated State Agency, and proper officials of the Federal Government, the constructing, equipping, maintaining and operating of suitable hospital facilities within the area served by such clinic to adequately care for persons suffering from illness or disabilities which require that such patient receive hospital care.

(b) To carry on such educational activities related to rendering care to the sick and injured or the promotion of health, as in the opinion of the Trustee-Directors of such Clinic may be justified by the facilities, personnel, funds or other requirements that are, or can be made, available.

(c) To promote and carry on scientific research related to the care of the sick and injured insofar as, in the opinion of the Trustee-Directors, such research can be carried on in, or in connection with, the hospital facilities available.

(d) To participate, so far as circumstances may warrant, in any activity designed and carried on to promote the general health of the community.

ARTICLE II.
BOARD OF TRUSTEE-DIRECTORS

Section 1. The corporate powers, business affairs and property of the Clinic shall be exercised, conducted and controlled by the Board of Trustee-directors to be appointed in the following manner: The Cherokee Lions Club, Cherokee, Alabama shall appoint the members of the Board of Trustee-Directors insuring at all times that representation on said Board is from the City of Cherokee, the areas West, South, East, and North of the City of Cherokee. In the event the Cherokee Lions Club declines to appoint Trustee-Directors or in the event the Cherokee Lions Club as presently constituted and organized, goes out of existence then the Trustee-Directors shall be elected by the then constituted Board of Trustee-Directors at least a month before the terms of office expire.

Section 2. Each director so appointed shall hold office for a term of six years, unless sooner removed, and until his successor is appointed and qualified with the exception that the first Trustee-Directors shall hold office for a term of years that corresponds to their name in the list of the original Trustee-Directors that follow: G.W. Perkins, Chairman, for a term of office as a Trustee-Director for six years; Herbert Harris, Jr., for a term of office of six years; Curtis Hester, for a term of four years; Malcolm Turberville, for a term of two years; and C.H. Stutts for a term of two years.

Section 3. A Trustee-Director shall receive no compensation for his services.

Section 4. Each of said Trustee-Directors shall be qualified to originate and take part in the discussion of any subject that may properly come before any meeting of the Board of Trustee-Directors, to vote on such subject and to hold office within the said clinic to which he shall be elected or appointed.

Section 5. Vacancies occurring among the membership of the Board of Trustee-directors shall be filled in the same manner as the provisions of Section 1 of this Article provide. The persons appointed to hold office for the unexpired term shall hold that office during the entire unexpired term and until his successor is appointed and qualified.

Section 6. The majority of the Trustee-Directors shall constitute a quorum at any meeting of such Board.

ARTICLE III.
MEETINGS

Section 1. The Board of Trustee-Directors shall meet quarterly at such times and places as may be designated by the Chairman of the Board.

Section 2. The agenda at such quarterly meeting of the Board shall be as follows:

(a) Call to order.
(b) Presentation and approval of minutes at last quarterly and of any special meeting held since such quarterly meeting.
(c) Transaction of business that may properly be brought before the meeting.
(d) Adjournment.

SPECIAL MEETINGS

Section 1. A special meeting of the Board of Trustee-Directors may be called by the chairman thereof at such time and place as in his judgement is deemed proper and expedient.

Section 2. Whenever a majority of the members of the Board of Trustee-Directors address in writing, to the chairman of said Board, a petition requesting that a Special Meeting of such Board be called, the chairman must upon receipt of this petition, thereupon give notice to each of the Trustee-Directors of the call of a Special Meeting to be held not less than seven days from the day of the receipt of such petition.

Section 3. The agenda of any special meeting shall be as follows:

(a) Call to order.
(b) Reading of the official call of the meeting.
(c) Transaction of the business for which the meeting is called.
(d) Adjournment.

NOTICE OF QUARTERLY AND SPECIAL MEETINGS

Section 1. Notice of each quarterly meeting and Special Meeting shall be mailed to each Trustee-Director, at his last known address, at least 3 days prior to the time of such meeting.

ARTICLE IV.
POWERS OF THE BOARD OF TRUSTEE-DIRECTORS

Section 1. The Board of Trustee-Directors of the Clinic shall have the power and authority:

(a) To conduct, manage and control the affairs and business of the clinic and to make rules and regulations for the guidance of the officers and management of its affairs.

(b) To appoint and remove officers, agents and employees of the clinic and to determine the manner of receiving, depositing and disbursing the funds of the clinic, and the form of checks and the person or persons by whom same shall be signed, with power to change such banks and the person or persons signing said checks and the form thereof at will.

(c) To cooperate with the State Board of Health for the purpose of constructing, equipping, maintaining and operating a hospital by making appropriate application to the State Board of Health and to enter into a cooperative contract with the State Board of Health for this purpose.

(d) To act as an agent for the State Board of Health under a cooperative contract to prepare, carry out, and operate hospital projects.

(e) To provide for the construction, reconstruction, improvement, alteration or repair of any clinic, hospital, or any part thereof.

(f) To manage, as agent of the State Board of Health, any clinic, hospital constructed or owned by the Clinic.

(g) To arrange with any appropriate local or State agency for the opening or closing of streets, roadways, alleys, or other transportation facilities.

(h) To lease or rent any land, building, structure, or facility needed in the operation of a Clinic or hospital.

(i) To enter upon buildings or property in order to conduct investigations or make surveys or soundings.

(j) To purchase, obtain options upon, acquire by eminent domain, gift, grant, bequest, devise or otherwise, any property, real or personal, or interest therein from any person, firm, corporation, city, county or government.

(k) To own, hold, clear, and improve property.

(l) To insure or provide for insurance of the property or operations of the Clinic against such risks as the Clinic may deem advisable.

(m) To borrow money upon its bonds, notes, warrants, debentures, or other evidences of indebtedness, and to secure the same by pledge of its revenues.

(n) To have perpetual session.

(o) To make and execute contracts and other instruments necessary or convenient to the exercise of the powers of the Clinic.

(p) To make, and from time to time amend and repeal, by-laws, rules and regulations not inconsistent with the laws of the State of Alabama.

ARTICLE V
DUTIES OF THE BOARD OF TRUSTEE-DIRECTORS

Section 1. It shall be the duty of the Board of Trustee-Directors:

(a) To keep a complete record of all its acts and of the proceedings of its meetings, to present a full statement showing in detail the condition of the affairs of said clinic once a year to the Cherokee Lions Club.
(b) To install a system of bookkeeping and auditing in keeping with the dictates of good business practices.
(c) To appoint a Medical Advisory Committee of three to five members from the medical staffs of the respective hospitals within the vicinity of said Clinic, such advisory committee to be responsible to the Board of Trustee-Directors for the professional aspect of the operation of such Clinic subject to the rules and regulations adopted by the State Board of Health.
(d) To receive and hold all money appropriated to said Clinic, and to pay out on certificate of said Board of Trustee-Directors such sums as may be required in payment of lawful obligations of said Clinic.
(e) To receive and administer all gift, donations or endowments for the Clinic falling within the jurisdiction of said board of Trustee-Directors, subject to the rules and regulations applicable thereto.
(f) To appoint such administrative officials as may be necessary in the operation of said Clinic and to determine the compensation to be paid to such administrative officials, and to supervise, in conjunction with the Medical Advisory Committee above named, the performance, by such administrative officials of their duties.

ARTICLE VI
OFFICERS

Section 1. The officers of the Clinic shall be a chairman of the Board of Trustee-directors and a secretary-treasurer, together with any other administrative officers whom the Board of Trustee-directors may see fit in its discretion to provide for by resolution entered upon its minutes.

Section 2. The secretary-treasurer of the Board of Trustee-Directors shall hold this office for a term of 2 years. This official is to be elected by the members of the Board of Trustee-Directors from their membership. The chairman shall be elected by the Cherokee Lions Club or by the Board of Trustee-Directors if the Lion Club fails, or desires not to act.

ARTICLE VII.

DUTIES OF OFFICERS

Section 1. The chairman shall:

(a) Preside over all meetings of the Board of Trustee-Directors.

(b) Call special meetings of the Board of Trustee-Directors and perform all acts and duties usually required of an executive and presiding officer.

(c) Should the chairman be unable to act, then the Board shall appoint a Trustee-Director among its number to act.

Section 2. The secretary-treasurer shall:

(a) Keep a complete record of all the meetings of the Board of Trustee-Directors.

(b) Serve all notices required by laws and by those by-laws, and shall make full report of all matters of business pertaining to his office to the Board of Trustee-Directors at the 1st quarterly meeting of each year.

(c) As treasurer take general charge of all funds of the Clinic under the direction of the Board of Trustee-Directors.

ARTICLE VIII.

ADVISORY COMMITTEE

Section 1. The Board of Trustee-Directors shall appoint a Medical Advisory Committee of three to five (3 to 5) members from the medical profession of the vicinity.

Section 2. The Medical Advisory Committee will be responsible to the Board of Trustee-Directors for the professional aspects of the Clinic's operations subject to the rules and regulations adopted by the State Board of Health.

I hereby certify that is a true copy of the By-Laws adopted by the Board of Trustee-Directors in a July assembled meeting on the 14th day of July, 1949.

(s) G.W. Perkins
As chairman of the Board of Trustee-Directors--West Colbert Healtn Clinic

Sworn to and subscribed to before me this 15th day of July, 1949.

(s) Howell Thos. Heflin
Notary Public

STATE OF ALABAMA

COLBERT COUNTRY

Know all men by these presents that the WEST COLBERT HEALTH CLINIC, INC., by and through its Board of Trustee-Directors, does hereby appoint the chairman of said Board of Trustee-Directors, the Honorable G.W. Perkins, to have the power of attorney to do and perform for the WEST COLBERT HEALTH CLINIC, INC. all necessary tasks in regards to entering into and signing, sealing, executing, acknowledging, certifying, and verifying any instrument, contract, or deed which the Board of Trustee-Directors has approved. The said Board of Trustee-Directors further empowers the said G.W. Perkins as its attorney to enter into pre-contractual negotiations with any interested party on behalf of said Clinic in any matter pertaining to said Clinic, but said G.W. Perkins is not to bind the said Clinic to any matter which hasn't been approved by the said Board of Trustee-Directors and it is to be clearly understood that the said G.W. Perkins doesn't have the power to bind the said Clinic to any provisions of a contract or an instrument which hasn't been approved by said Board of Trustee-Directors.

Approved by a duly assembled meeting of the said Board of Trustee-Directors on this 14th day of July, 1949.

(s) Malcolm R. Turberville
Secretary-Treasurer

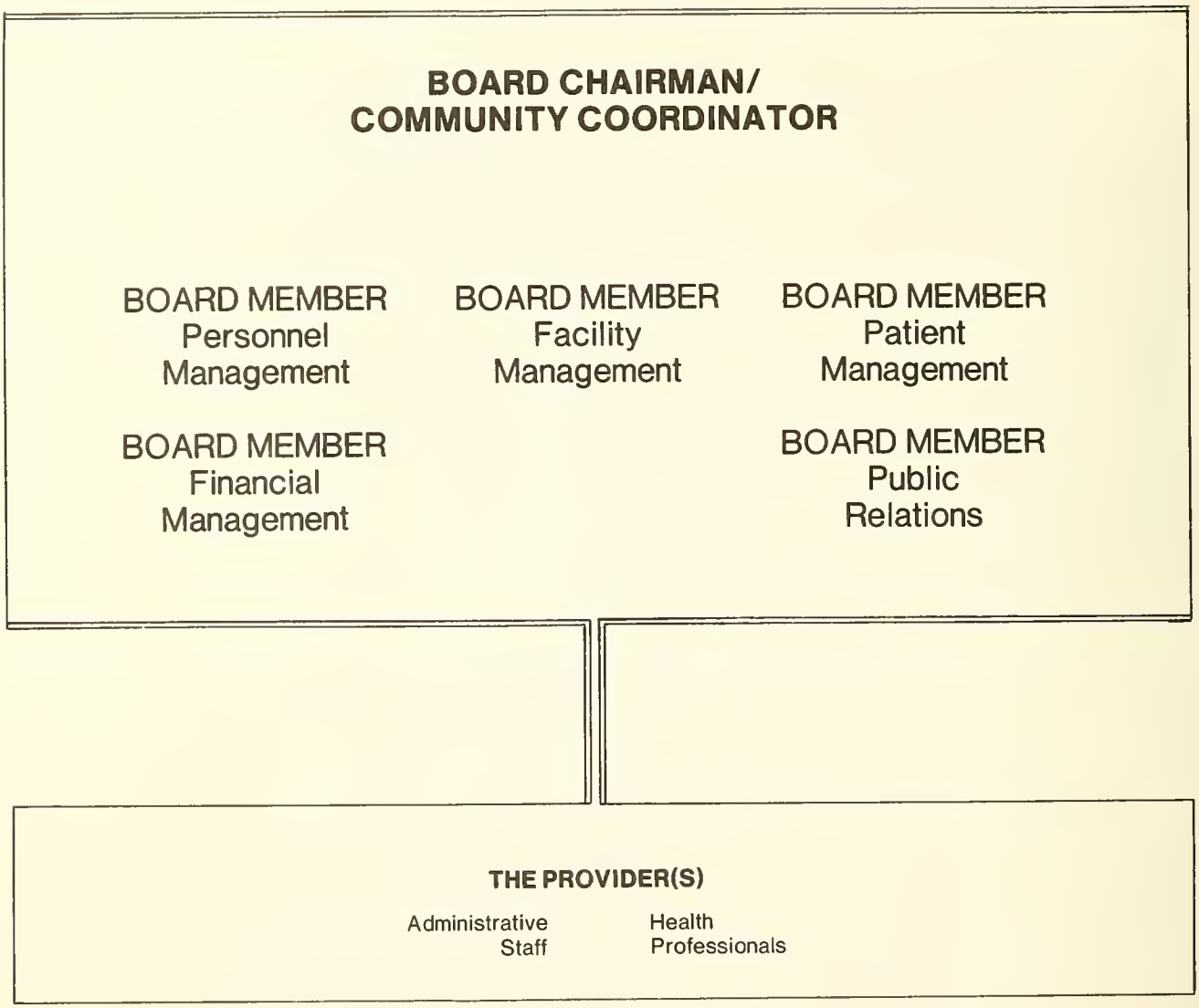
STATE OF ALABAMA
COLBERT COUNTY

I, George H. Copeland, Judge of Probate in and for the State and County aforesaid do hereby certify that the foregoing is a true and correct copy of an instrument as shown of record in Vol. 4 page 531-540 Given under my hand and official seal of office this 12 day of June, 1973.

(s) George H. Copeland
Judge of Probate

EXHIBIT 2

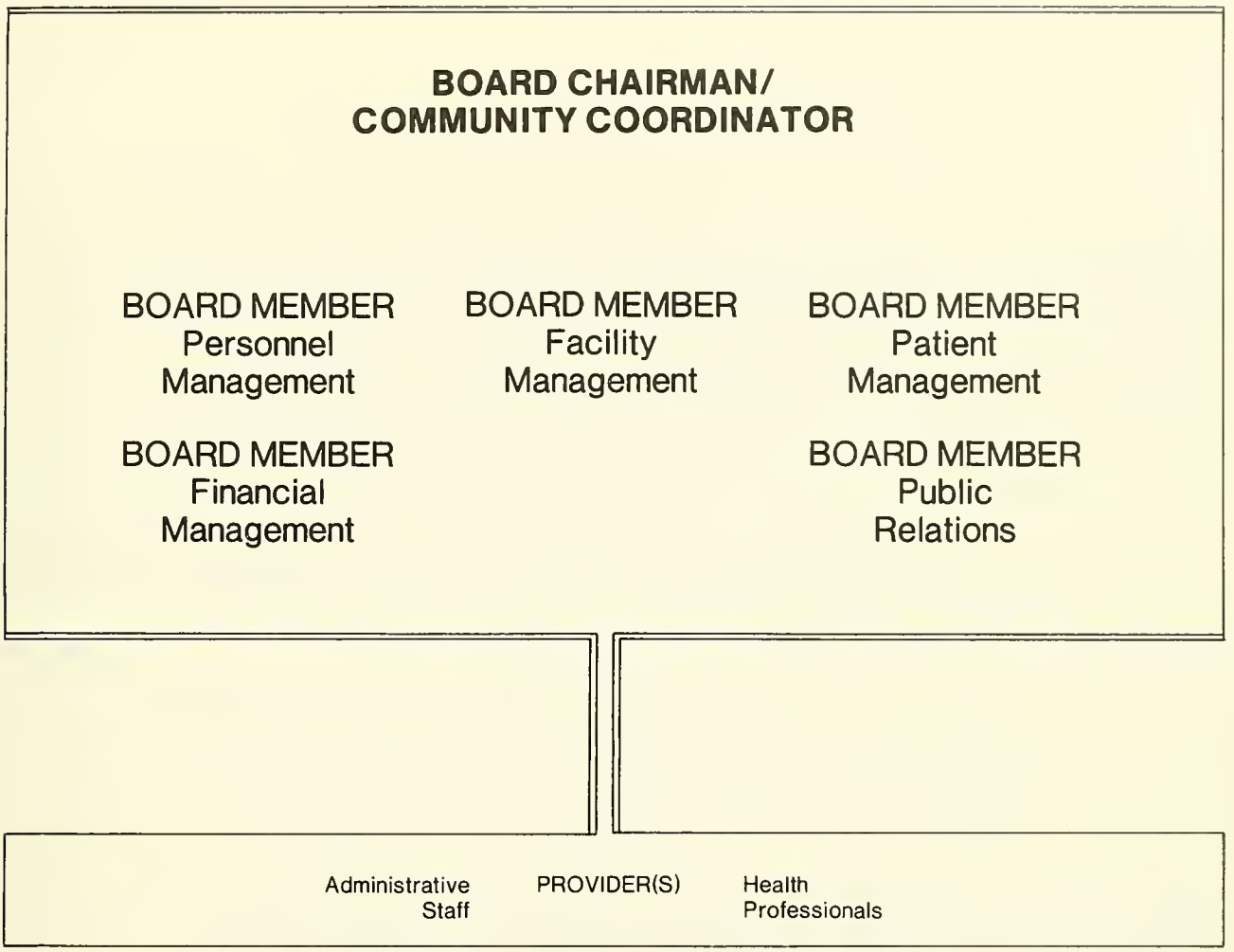
SAMPLE TABLE OF ORGANIZATION



In this example, the provider and the Board have agreed that the provider will share in all Board management responsibilities.

EXHIBIT 3

SAMPLE TABLE OF ORGANIZATION



In this example, the Board and the providers have agreed that the Board has the full responsibility for the management of the practice.

EXHIBIT 4

SAMPLE PERSONNEL POLICIES

Introduction

The information contained in these Personnel Policies covers many subjects and is necessarily very general in its nature. This information is intended only to acquaint you with the most important policies of the practice and is not to be construed as detailing all of your rights or obligations thereunder. If you have any questions, see the person designated to supervise your activities. (See Mary Smith of the Board's personnel committee.)

Employment Policies

First priority for employment for all vacancies that exist within the practice is given to local residents. Additional criteria include physical and mental ability, training, individual skills, and proper certification in those positions that require local, state, or national registration, and/or licensure.

Equal opportunity will be afforded to all applicants.

Probationary Period

Every employee is employed on a probationary basis for the first four months of employment. During this time the individual and the practice can individually and mutually determine whether or not continuing employment is beneficial to both parties. At the end of three months of employment the employee will be rated as excellent, good, average, below average, or unsatisfactory. This rating will be based on personal and demonstrated qualifications such as initiative, dependability, ambition, judgment, ability to do the work required of the position, and ability to get along with fellow workers. The results of this rating should be discussed with the employee. At the end of the fourth month, employment will be rated, reviewed, and discussed with the employee by Mary Smith. After successful completion of the probationary status, the employee will become a regular employee.

EXHIBIT 4 (CONT'D)

Wages and Salaries

Every employee will be quoted a salary prior to employment. All employees will be formally evaluated at the end of one year of employment, and salary increases will be given upon successful evaluation by the supervisor and recommendation by the supervisor based on effectiveness of work performance and dependability. No overtime work shall be authorized without the approval of John Jones of the Board's finance committee. Other regulations regarding overtime shall be in accordance with the current federal wage and hour laws. Although there are no time clocks within the practice, employees are expected to arrive promptly on time and not leave before the time which they are scheduled to leave.

Pay Period

A biweekly pay system is used and taxes are withheld in compliance with federal and state legislation. Taxes will be withheld according to the number of dependents claimed. Contribution to Social Security are made by the practice and the employee in accordance with federal regulations.

Health Care

Health care is available for all employees. A group health insurance plan is available to all employees and dependents.

Change in Personal Information

All employees are required to report changes of the name, marital status, number of dependents, address, or phone number to John Jones of the Board's finance committee.

Disciplinary Action

Naturally we expect that every employee will conduct himself in a manner which will bring credit to the practice. Where indicated, disciplinary action in the form of suspension without pay or dismissal may be taken against an employee. A few of the activities for which disciplinary action may be taken against an employee are disorderly conduct, poor performance, insubordination, disloyalty, excessive tardiness, unauthorized use or removal from premises of any equipment or supplies, and discourtesy to a patient, client, or visitor to the practice. If after adequate counseling and warning, an employee's services are still found to be unsatisfactory, the personnel committee shall have the authority to terminate the employee. Each employee will be offered an exit interview with the director.

Non-Discrimination

We certify that we will not now or in the future discriminate on the basis of race, creed, sex, color, age, national origin, religious beliefs, physical handicap, marital status, ancestry, or liability for service in the Armed Forces of the United States or have any interest to make any limitation, specification, or discrimination unless based upon a bona fide occupational qualification.

EXHIBIT 4 (CONT'D)

Publicity and Public Relations

Each employee plays an important and continuing role in interpreting the practice to the community. However, all communications with news media personnel must be issued by the public relations committee of the Board. All public appearances or talks by personnel concerning the functions of the practice must be cleared with that committee.

Conclusion

You are now a member of the Justice Health Clinic, and as a member it is hoped that you will share your talents to make your employment here a mutually rewarding experience.

I have read and agree to abide by the Personnel Policies of the Justice Health Clinic.

THE PREOPERATIONAL BUDGETING PROCESS

2

INTRODUCTION

At this stage in the development of the community organization, detailed attention must be given to the monetary requirements associated with your plans to administer and finance a clinic. Even though it may be several months before your clinic begins operations, the process involved in preparing a budget will surface several potential areas of concern related to financing. For instance, it is not unusual for a community organization to have to raise several thousand dollars to defray organizational and start-up costs. These guidelines should identify some of the types of costs that you may expect, as well as help you develop a budget that may be used for fiscal planning.
This booklet was prepared under Contract no. HSA 105-74-211 by Family Health Care, Inc. 1910 K. St., N.W. Washington, D.C. 20006.

THE PREOPERATIONAL BUDGETING PROCESS

2

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ESTIMATING THE AMOUNT OF PREOPERATIONAL COSTS

Organizational Costs

1. Definition and Examples

Not to be confused with start-up costs, organizational costs will normally be incurred by communities while in the act of forming a nonprofit corporate organization. Examples of organizational costs are underwriting fees, commissions, promotional costs, costs of raising capital, legal and accounting fees, drafting the corporate charter and bylaws, and expenses of temporary directors and of organizational meetings of directors. Some of the above expenses may even be incurred after the practice opens. For instance, during the early months it may be necessary to raise additional capital. The capital (loan, donations, etc.) itself would not be considered, but all the incidental expenses (travel, clerical, supplies, telephone, etc.) would be properly classified as organizational costs. Also, additional promotional costs may be incurred after the practice has begun operations. Similar costs may also be recognized if it becomes necessary to expand the practice during the early months.

2. Capitalization of Organizational Costs

Organizational costs may be recognized only during the first *taxable* year in which the practice operates. The significance of observing and classifying organizational costs stems from the related accounting treatment. For accounting purposes (and usually for tax purposes) these costs should be treated as an intangible asset of the corporation and depreciated much like tangible assets of the corporation. In other words, organizational costs should not be treated as an operating expense during the first year of operations. Rather, it is acceptable to lump these costs together and record them as an asset, and to systematically depreciate them over a period of *not less than 60 months.* However, if the practice should terminate prior to the end of the 60-month period, the total balance not recovered through depreciation may be reported as an operating expense at the date of termination.

Start-up Costs

1. Length of the Start-up Period

For purposes of financial planning, the start-up period is the period of time within the first year of operations during which the total patient receipts are insufficient to cover all the obligations associated with the project. Although each NHSC practice experiences a different set of start-up expenses and demands for services, the start-up period typically extends into the first six to nine months of operations.

The total patient receipts also vary according to the amount of third party billing (insurance companies, Medicare, Medicaid, etc.), the credit policy in force, and the overall economic conditions in the area. Generally, NHSC practices located in communities with average and above average income levels, which have written credit policies and procedures, and comprehensive third party coverage, have the best chance of covering all of the project's obligations within the first six to nine months of operations. On the other hand, depressed economic conditions in the area, coupled with a lack of written credit policies and procedures, and an absence of third party coverage, may result in a deficit lasting beyond the first nine months of operations.

As part of the budgeting process, it is recommended that you ask your community agencies for such statistics as the median family income and the rate of unemployment in your service area, to assist you in gaining insight into the relative economic conditions. Similarly, you can obtain valuable information regarding the extent of third party coverage by inquiring among the area's physicians and other health professionals.

2. Classification of Start-up Costs

a. Professional and office equipment represent the most common and major start-up costs. (For guidelines on planning for equipment needs, please refer to the NHSC Guide Book Number 3, "The Medical Facility, Equipment and Supplies.")

If the equipment is purchased, it may be paid for in a lump sum or, if your start-up funds are limited, on an installment basis. An additional expense for interest will have to be incurred with installment payments. Long-term installment purchases should generally be avoided, since the original term of the Memorandum of Agreement with the NHSC is for only two years. Of course, the MOA may eventually be extended, if the community meets its obligations. The availability of future health manpower to replace the NHSC assignee is another factor that should be considered at this time, so that long-range commitments will be carefully executed.

Although leased equipment is expensive, it is commonly used (especially for tax purposes) and should be seriously considered when outfitting new offices. Leasing companies (lessors) will usually agree to sell equipment to the lessee after the expiration of the lease for a percentage of the original purchase price. This is referred to as a lease with an option to buy. If entered into, the period of any lease agreement should be limited to the life of the NHSC Memorandum of Agreement. A renewal option should also be included as part of the lease package.

For those projects classified under the NHSC reimbursement Option No. 1 (Percentage Distribution Method), the differences between leasing and installment purchase contracts are significant. Lease payments may be made directly from the patient collections of the practice with the full payment considered as a "preferential" operating expense. (In the NHSC accounting guidelines, these payments would be considered Category B, preferential expenses.) On the other hand, installment purchase payments, with the exception of that part identified as interest, would not be considered as an operating expense. This means that purchase installment payments would not receive preferential treatment in determining those patient fees that accrue to the corporation.

Under the installment contract, the related equipment should be recorded as an asset and depreciated over its useful life. Although the depreciation may be recovered directly from the patient collections, the benefits of spreading this type of recovery over the useful life of the equipment, generally 8 to 12 years, will be less immediate than under a leasing arrangement.

Before any purchase or lease decisions are made, the total costs as well as the monthly payments should be clearly listed. Also, you should consider how the equipment will be used after expiration of the NHSC Memorandum of Agreement. For these reasons, and the others listed above, it is suggested that legal counsel be consulted before entering into high cost lease or purchase contracts. The NHSC will also assist you in these areas of budget planning.

b. The Facility: The start-up funds required to renovate or otherwise prepare the facility for operation often represent another expensive item. Labor and material costs may be substantial if the building designated for the clinic requires major renovations. If the facility is to be leased, the lessor may require a long-term lease for extensive renovations to be undertaken. The pitfalls related to long-term leases have been described in the previous section. Since renovations are normally considered an intangible asset (for both accounting and tax purposes), the corporation's cash outlay can be recovered only through depreciation of the asset. That is, depreciation of material renovations are considered, under Option 1, a preferential operating expense and will increase the percentage of fees that accrue to the community over the life of the asset.

If the community, as a tenant, renovates leased property, depreciation may be spread over the relatively short period of the lease (if the lease corresponds to the life of the MOA). But if the community corporation renovates a facility that it owns, depreciation must be spread over a much longer period. In this case, the cost of renovations must be depreciated over the useful life of the portion renovated or over the life of the medical facility, whichever is less.

In summary, leasing and/or renting will look attractive in many situations. However, in some cases, the advantage of ownership outweighs the advantages of the more expensive leasing arrangements. As mentioned before, these decisions cannot be made without considering the long-term alternatives that will be available after the MOA expires.

3. Initial Supply Inventory

Before you can begin operations, an initial inventory of professional supplies should be obtained. Buying supplies may take several weeks. It is therefore recommended that ample time be allowed for all of the supplies to arrive. (A more complete discussion of this subject may be found in the NHSC Guide Book, Number 3, "The Medical Facility, Equipment and Supply.")

4. Start-up Reserve Funds

In addition to covering the expenses outlined above, it will be necessary to establish a reserve fund sufficient to cover operating deficits incurred during the start-up period.

5. Other Start-up Costs

It is recommended that you employ one or two individuals prior to beginning operations to assist in setting up the facility. It is wise to attempt to involve the NHSC assignee in the selection of the staff, but sometimes this is not possible. (For further information regarding the selection of personnel, please refer to the NHSC Guide Book Number 4, "The Staff.")

6. Summary: It is suggested that you prepare a worksheet summarizing the statistics you gather and your estimate of the start-up funds required. A possible format for the worksheet appears in Exhibit 1.

EXHIBIT 1

INITIAL PREOPERATIONAL WORKSHEET AND BUDGET

COMMUNITY INFORMATION

A. Economic conditions within the service area

1. Median family income _____
2. Unemployment rate _____

B. Expected sources of payment within the service area

% of population

1. Medicare _____
2. Medicaid _____
3. Other 3rd parties _____
4. No coverage _____

TOTAL 100%

PREOPERATIONAL BUDGET

A. Organizational costs

1. Legal and accounting fees _____
2. Promotional costs _____
3. Stock certificate costs _____
4. Underwriting fees _____
5. Incorporation fees _____
6. Commissions _____
7. Costs of raising capital (legal and accounting fees, printing, clerical, etc.) _____
8. Other _____

SUBTOTAL _____

B. Start-up Costs

1. Professional and office equipment -
   Down payment _____
   12 monthly purchases/installments totalling (excluding interest) _____

   SUBTOTAL _____

2. Facility
   Renovations - annual cash outlay _____
   12 monthly mortgage payments totalling (excluding interest) _____
3. Beginning inventory - professional and office supplies _____
4. Start-up reserve _____

SUBTOTAL _____
TOTAL _____

PREPARATION OF THE ANNUAL OPERATING EXPENSE BUDGET (SEE EXHIBIT 2)

1. Directions for Completing the Annual Operating Expense Budget:

Line 1 Salaries and Benefits: Enter here the projected annual salaries and benefits for medical personnel required to support the NHSC assignee(s). You may also include accounting, legal, and consulting fees. Administrative personnel salaries for projects with 3 or more medical/dental providers may be included in this category. (All other administrative salaries should be included in Line 9.) Salaries paid by the NHSC should not be included in your budget. (To assist you in determining the staff size and composition, please refer to the NHSC Guide Book Number 4, "The Staff.")

Line 2 Payroll Taxes: Enter here the annual employer payroll taxes which you anticipate based upon the salary expense entered in Line 1. This item includes such taxes as the employer's portion of the FICA tax, FUTA taxes, state employment Security Commission contributions, etc.

Line 3 Self-explanatory.

Line 4 Professional Supplies: Included in this category will be expendable supplies used by the professional staff, drugs, laboratory expenses, nonexpendable professional supplies having a limited useful life, uniforms expense, medical records forms, accounting supplies, and medical books and prescriptions.

Line 5 Professional Equipment Rental or Depreciation: Only professional equipment rental or depreciation should appear on this line. Examples are: X-ray units, telephone answering equipment, ADP equipment, etc. Rental and depreciation of the facility should be included in Line 10.

Line 6 Self-explanatory.

Line 7 Rent and Utilities: Should include all utility and rent expenses associated with the facility(s). If the NHSC occupies only a portion of the facility, these types of expenses must be prorated.

Line 8 Office—Supplies and Equipment Rental: Please note that accounting supplies are not included in this category, but rather, on Line 4.

Line 9 Miscellaneous Expense: This category includes all other expenses incurred by your community in support of the project not otherwise accounted for in categories A, B, or C. Examples of typical miscellaneous expenses are: insurance expense, interest, transportation expenses, etc.

Line 10 Other Depreciation: Enter here the depreciation expense associated with the facility and office equipment, such as typewriters, adding machines, desks, etc. Please note that depreciated expense associated with professional equipment is included on Line 5.

Lines 11 and 12 Self-explanatory.

EXHIBIT 2

ANNUAL OPERATING EXPENSE BUDGET

Field Station: _____ **Year Beginning:** _____

OPERATING EXPENSES:	
CATEGORY A (SUPPORT PERSONNEL)	
1. Salaries & Benefits (Exclude NHSC Personnel)	
2. Payroll Taxes	
3. Subtotal Category A	
CATEGORY B (MEDICAL SUPPLIES & EQUIPMENT RENTAL)	
4. Professional Supplies	
5. Professional Equipment Rental or Depreciation	
6. Subtotal Category B	
CATEGORY C (ALL OTHER ADMINISTRATIVE OVERHEAD)	
7. Rent and Utilities	
8. Office Supplies and Equipment Rental	
9. Miscellaneous Expenses	
10. Other Depreciation	
11. Subtotal Category C	
12. TOTAL EXPENSES	

ESTIMATING THE AMOUNT OF ANNUAL REIMBURSEMENT TO THE NHSC

Section 329 of the Public Health Service Act provides that the NHSC recover its reasonable cost of providing health care pursuant to established regulations. As a result, two options have been developed to enable the NHSC to recover its costs and, at the same time, provide a mechanism for the community to recover its in-kind and real investment toward equipment, supplies, facilities, and support staff. For communities having an ongoing health provider system and meeting certain other criteria, the NHSC should be reimbursed its total average reasonable cost regardless of the income experience of the medical or dental project. This method will be known as Option 2. For new projects in communities with limited or no previous experience in health care systems, reimbursement Option 1 has been developed.

It has been said that Section 329 of the Public Health Service Act contemplated not only a charge for services based on the cost of providing services, but also a distribution (to the NHSC and to the community) of fees collected on approximately the same basis.[1] This basic philosophy has been built into reimbursement Option 1 and permits the community to reimburse the NHSC based on the availability of fees collected by the community. In addition, the community may pay for certain direct operating costs before any of the fees accrue to the NHSC. After these "preferential" operating costs are paid for from the fees collected, a percentage of the balance of fees (net receipts) shall be distributed to the NHSC. The operating costs receiving "preferential" treatment are described as Category A (support salaries) and Category B (professional supplies/equipment) expenses.

Annual budgetary limits have been placed on these preferential expenses that may be recovered directly from the medical/dental fees collected. Category A and B expenses that exceed the budgetary limits must be paid from the community's share of fees remaining after providing for the NHSC share. The annual budgetary limits will vary according to the number of assignee providers. (The budgetary limits may be obtained from your NHSC Regional Office.)

Category C expenses (administrative overhead) will be compared to the average reasonable costs paid by the NHSC (NHSC providers' expenses, start-up funds and government equipment and supplies) to determine the ratio in which the net receipts will be distributed to both parties.

The NHSC's percentage share of the annual medical/dental fees will be due and payable on a quarterly basis under both Option 1 and Option 2. Although it may be difficult to estimate the budgeted revenues (medical/dental fees), your operating budget will at least provide the estimated preferential expenses that you may expect to cover from the fees collected.

Your Statement of Operations, which will be used to report revenues and corresponding expenses to the NHSC, also provides a section for determining in advance the amount owed. Accordingly, a check should be submitted at the same time that you submit the statement. Mailing instructions are provided directly on the face of the Statement of Operations, Parts I and IV.

OPERATING CASH REQUIREMENTS

The "Total Expenses" arrived at in developing the "Annual Expense Budget" will not equal the cash required to operate the project. Expense items such as "Depreciation" are included in the budget, but do not represent a cash outlay. Similarly, mortgage and other loan payments require cash outlays, but should not appear in the budget as an operating expense.

Therefore, to determine the total amount of cash required from operations, you must deduct from "Total Expenses" (Line 12) all of those expense items not requiring cash outlays, and add all cash disbursements not reflected on the budget. Exhibit 3 outlines this process.

[1]Memo from Office of the General Counsel, DHEW - "NHSC - Reimbursement Options - Recovery of Reasonable Costs."

EXHIBIT 3

CASH REQUIREMENT

TOTAL EXPENSES (Line 12, "Annual Expense Budget")		$ _____
Subtract:		
Depreciation		$ _____
Start-Up Reserve		$ _____
Add:		
Mortgage Payments		$ _____
Installment Loan Payments		$ _____
Other Loan Payments		$ _____
NHSC Reimbursement		$ _____
	TOTAL CASH REQUIRED	$ _____

AMOUNT OF BUSINESS NEEDED TO MEET THE TOTAL CASH REQUIREMENTS

Knowing the total cash requirements, it is possible to approximate the number of patient visits needed per week in order to cover these requirements. The method used to approximate the needed patient volume is shown in Exhibit 4.

EXHIBIT 4

NUMBER PATIENT VISITS NEEDED TO COVER CASH REQUIREMENT

STEP 1: Determine annual number of visits required:

$$\frac{\text{Total cash requirements}}{\text{Average area office visit fee x 1.35}} = \text{Annual No. Visits}$$

STEP 2: Determine weekly number of visits required:

$$\frac{\text{Annual number of visits}}{\text{45 weeks x number of physicians}} = \text{Weekly No. Visits}$$

THE MEDICAL FACILITY, EQUIPMENT AND SUPPLIES

3

INTRODUCTION

Your medical facility should provide an environment that is attractive and pleasing to both patients and staff. This can be achieved without excessive cost through careful planning.

A patient's opinion of your practice is formed by many things, one of which is the appearance of the facility. In addition, internal design of the facility greatly influences the efficiency and performance of the staff.

The type of medical services that will be available at your health center, and the funds available, will determine the equipment and supplies needed. Careful attention should be given to the planning of your medical facility, and to the purchase of equipment and supplies. This booklet was prepared under Contract no. HSA 105-74-211 by Family Health Care, Inc. 1910 K. St., N.W. Washington, D.C. 20006.

THE MEDICAL FACILITY, EQUIPMENT AND SUPPLIES

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THE FACILITY

What kind of a facility do you need?
Each NHSC sponsoring Board is responsible for establishing the practice facility. The kind of medical facility needed is one which will accommodate the type of medical services the sponsoring Board and provider have decided will be delivered, and it should be designed with this in mind. For example, if the practice expects to have two physicians providing general medical services, and if the practice will include limited laboratory and X-ray procedures, then the facility should ideally have space for:

- four exam rooms
- two consulting rooms
- a waiting room
- one nurses' station
- a small laboratory
- an X-ray room
- three lavatories
- one storage room
- one reception/business/medical record room

Keep in mind that some states dictate prescribed specifications for a medical facility, such as size and number of examination rooms. Check with the Comprehensive Health Planning Agency in your locality to determine whether your state has special facility requirements.

Should you renovate, lease or build your facility?
Once the decisions have been made on the general specifications of your facility, the sponsoring Board must determine whether to renovate, lease or build the facility. This decision will depend upon several factors:

- desired location
- financial resources
- the availability of buildings with the necessary potential for renovation

Where should the facility be located?
The location of your medical practice determines to a large degree the number of people who will use it. People tend to use facilities that are accessible and convenient. If you have several options available to you, the selection should be the site which is located in the most densely populated portion of the area to be served by the facility. An example of this is the business area of the county seat or some other center of community activity. Points to consider are:

- accessibility to roads and public transportation
- proximity to other health care resources (hospital, dental services, nursing home)
- a suitable terrain (adequate drainage, easy accessibility in snow/rain)
- local zoning requirements
- county or municipal building codes and utility requirements
- availability of water, sewer service, electricity, fuel and trash/garbage disposal
- adequate space for parking

In selecting a facility location, consider one that will present the fewest transportation problems for handicapped patients. In addition, if the facility is located above or below the street level, there should always be an elevator or a ramp for the use of handicapped patients and/or staff.

In all cases, your practice should be clearly identified by an outside sign and sufficient outdoor lighting so that potential patients are aware of its location.

Remember that there are resources available to assist in planning the facility. Some of these resources are:

- the local medical society
- the Community Health Planning Agency in your locale
- health facility architects

How should the interior be designed, finished and maintained?
The facility should be designed to provide efficient use of the available space and at the same time provide an attractive environment for patients and staff.

When designing the interior of your facility, the following areas should be given special attention and all considerations should be discussed between the sponsoring Board and the assignees, if possible, before final decisions are made.

- Waiting Area
  - ☐ Location of the waiting area should be immediately inside the front entrance so that the receptionist can see patients as they arrive and leave.
  - ☐ Comfortable and sufficient seating should be available for waiting patients. As a rule of thumb, the minimum should be two seats per examination room.
  - ☐ Space should be provided for a coat rack.
  - ☐ Enough space should be allowed for children's quiet activities. This space might have a small table, chairs and some children's books.
- Receptionist and Business Area
  - ☐ Should be easily accessible to both patients and staff.
  - ☐ Should be located in a manner that allows the receptionist to clearly view the waiting patients.
  - ☐ Should be convenient to the provider's work area to facilitate communication and supervision of:
    patient traffic
    flow of medical records
    billing information.
  - ☐ The space for medical record storage should be convenient to the receptionist or appointment clerk's work area.

- ☐ Enough working area should be given to the receptionist to allow performance of tasks with maximum efficiency. The usual amount of space allowed for this purpose is 60 sq. ft./individual working in this area.
- ☐ If possible, a separate space or room should be near the receptionist/business area to allow for private discussion related to registration or billing questions.
- ☐ In larger offices it may be advantageous to have separate areas or windows for reception and payments.

- Examination Rooms and Consultation Rooms
  This section of your facility should form a well integrated unit. Each room should provide complete privacy for the patients and yet be easily accessible to the providers.
  - ☐ Exam/treatment rooms
    The number, size and design of these depends largely on the number of patients seen and the types of service available at the practice. As a rule of thumb, a minimum of two exam/treatment rooms per provider is needed. The size of the exam/treatment room is important. If too small, the provider may not have enough space around the examination table to comfortably perform some procedures and, if too large, patients are likely to feel a lack of privacy. A good space allotment for an exam/treatment room is 9' x 11'. Pediatric examination rooms are frequently a little smaller. At least one exam/treatment room should have a door wide enough to permit entrance of a stretcher patient or wheelchair (3'8").
  - ☐ Consultation rooms (physician's office)
    Each provider needs a private office in which to consult with patients and other providers, as well as to conduct the normal business of the practice. In most cases this room does not have to be very large. It should have enough space for a desk, bookcases and chairs (approximately 100 sq. ft.). Since the majority of patients complete their visit in this room, it should be located between the examination area and the waiting room. Frequently, limited space may require the consultation area to be combined with one of the exam/treatment rooms. Such a combination room should be at least 120 square feet.
- Lavatories
  The number of lavatories needed in your facility will depend on the expected size of your practice. However, every facility needs at least one lavatory. Easy access to the lavatory is very important, both for people waiting and for patients being treated. Some states require two lavatories in the facility in order to qualify for provider status.
  - ☐ If laboratory work is done on the premises, a lavatory should be located next to it. A shuttered pass-through window for specimens is desirable.
  - ☐ Ideally, a staff lavatory should also be provided.
- Other Work Areas
  The other work areas in a clinic might include laboratory, X-ray and utility/storage.
  - ☐ Laboratory
    To save steps, this room should be centrally located relative to the examination rooms and lavatories.
  - ☐ Utility room(s)
    Since most of the soiled linen and supplies are kept in this room, it should be easily accessible from the exam/treatment rooms.
  - ☐ X-ray room
    Special shielding accommodations must be made because of the dangers of radiation. If you plan to have X-ray equipment at your clinic, you should speak to the distributor of that equipment about location, electrical wiring and lead shielding. Health departments in many jurisdictions have a physicist available to advise you on X-ray shielding requirements.
- Corridors/Traffic areas
  Another consideration in a well-organized office is the design of the traffic areas.
  - ☐ Corridors should be wide enough for two-way traffic (preferably, at least four feet).
  - ☐ Traffic areas should not be obstructed by equipment and supplies.
  - ☐ Corridor space should not be used for storage under any circumstances.
  - ☐ Remember that fire regulations require that all doors open into rooms and not into the corridors.
    This will also assure patient's privacy in the examination room.
- Parking Space
  Off street parking is preferred. Adequate parking for both staff and patients should be available.

Once the Board and, if possible, the assignees have agreed to the basic interior design, decisions should be made on the interior fixtures and decoration. Careful attention should be paid to such things as the lighting, floor covering, plumbing fixtures, wall paint and acoustics.

- Lighting
  Medical and work areas require good overhead lighting.
  The waiting room should have lighting suitable for reading.
  Entrances and parking areas should be well lighted.
- Painting
  The rooms should be painted in a somewhat neutral color. Many providers prefer a medium to light green which helps them to determine skin tone. Save the bright yellows and oranges for the waiting area and corridors.

- Floor Covering
  Carpeting is desirable for the reception area and corridors. Lavatories and exam rooms should have a smooth surface that can be easily and frequently cleaned and disinfected.
- Plumbing Fixtures
  Each examination room, and the laboratory, should have a sink. If possible, the sinks should be equipped with wrist action faucets and a gooseneck spout.
- Acoustical Considerations
  Patient privacy is of a primary consideration. Examination rooms, consultation rooms and any areas where confidential medical information is discussed should be adequately soundproofed so that these conversations will not be overheard in the waiting area or the adjacent exam room.

Because patients rightfully expect a medical facility to be spotlessly clean, it is very important that the Board establish cleaning schedules which are rigorously followed. It is also important to adequately maintain all the vital systems of the facility, such as plumbing, heating and utilities to insure efficient and continuous delivery of services. As an example, without a maintenance schedule for the heating plant, an unexpected breakdown might force the facility to close down for several days. Not only would patient revenues be lost, but the expenses associated with heating repair or replacement could be considerable.

- Repairs and General Maintenance
  - ☐ The Board should compile a list of the names, addresses, and telephone numbers of local plumbers, electricians, carpenters and heating/air conditioning firms. In addition, a list of the addresses and telephone numbers of public utilities and fuel suppliers should be available to the receptionist.
  - ☐ The authority to contact any of these services should rest with one person in the practice.
  - ☐ The outdoor environment should be groomed and maintained since it contributes to the impression your practice makes. Areas for consideration are:
    Lawn mowing
    Snow removal
    General landscaping
- Cleaning
  - ☐ Devise a cleaning schedule (See Exhibit 1, Sample Cleaning Checklist, page 5).
  - ☐ Each staff member can assist by maintaining general order in his/her own work area.
  - ☐ The practice should compare the cost of contracting for maintenance work with the direct hiring of a full or part-time maintenance employee. The final decision should be based on the amount of work to be done, cost of equipment, available storage space and cost of labor.
  - ☐ Inspection should be performed on a regular basis by a Board-authorized person in order to maintain defined standards of cleanliness. This can also be used to evaluate housekeeping personnel or a maintenance contractor.

EQUIPMENT AND SUPPLIES

What factors should be considered when selecting and purchasing equipment and supplies?

The type of equipment and the quantity of supplies on hand are generally determined by the number of providers and the type of services your practice expects to deliver to patients. The following specific considerations should be taken into account:

- The amount of money available in your budget for equipment and supplies.
- The price difference among various vendors.
- The possibility of purchasing at a discount through already-established providers, such as a hospital.
- The amount of storage space available.
- How often the equipment will be used.
- Specialty areas which the practice will cover. For example, simple orthopedics will require casting equipment.
- Specialty services available in the area, which the providers could use for referrals. For example, a local obstetrician may have all the obstetrical equipment needed.
- The amount of time needed in ordering supplies and equipment to insure delivery before the opening date of the facility.
- The experience of other medical practices or facilities in the area with specific pieces of equipment.
- The quality of maintenance provided by local vendors.
- The possibility of leasing versus purchasing.
- The possibility of renting or obtaining used equipment.

Some tips to follow when selecting medical equipment and supplies for your practice.

- Obtain a list of equipment and supplies from a practice providing similar medical services or utilize the services of a health equipment consulting firm (See Exhibit 2, Sample Furniture and Equipment List, page 6).
- Make a list of the medical areas in the facility. Under each of these headings, list the instruments, equipment and consumable supplies typically used in each of these areas. Include prices where possible.
- Discuss the equipment and supply list with an experienced medical provider prior to purchasing and inquire about his/her special needs or

preferences as well as priorities.
- Determine the quantities required.
- Compare prices of several vendors and determine lead time needed to place orders so as to assure early delivery.
- Prepare a final list which includes quantities, procurement source and costs, then review the total package with the NHSC provider.
- Investigate the possibility of purchasing at a discount through a local hospital.

Remember that expensive instruments should be shared by two or more providers.

Some tips to follow when selecting nonmedical equipment and supplies.
- Visit another medical practice and, if possible, talk to the receptionist/bookkeeper about the kinds of nonmedical equipment and supplies needed (See Exhibit 2, Sample Furniture and Equipment List, page 6).
- Make a list of the nonmedical areas and determine the office equipment and supplies typically needed.
- Evaluate the available space and then decide on the type and quantity of office equipment and supplies the facility can accommodate.
- Investigate the variety of telephone answering services available.
  The following types of systems should be reviewed:
  - ☐ Telephone company equipment
  - ☐ Other commercial equipment
  - ☐ Private answering services

  Vendors of this equipment should be invited to make presentations to the Board and providers so that a decision can be made on the type of telephone answering system most suitable for your provider and practice.

How should equipment and supplies be purchased and maintained?

When possible, equipment and supplies should be purchased from local vendors to assure adequate and speedy service. This is particularly important when maintenance or repair of equipment is necessary. Patient care could be seriously compromised and practice revenues curtailed unless equipment is continuously in working order.

Prior to the opening of the facility, the Board should authorize one of its members to make the agreed upon purchases. This individual will then be responsible to do the following:
- Prepare the purchase orders
- Monitor the vendors to assure prompt delivery
- Check the equipment and supply items delivered against the purchase orders.

Once the staff has been hired and the practice is operating, one employee should be authorized by the Board as the purchasing agent. The Board should also have a written purchasing policy that contains at least the following internal controls:
- All capital equipment in excess of $100 should be authorized in writing by the Corporation Executive Board or other designated official.
- Requisitions for supplies in excess of $100 per order should be authorized in writing by the Corporation Executive Board or other designated official.

Good purchasing procedure should include the following:
- **Requisitions** - Control of purchases can be maintained through the use of requisition slips. Requisitions should be prepared by the employee responsible for purchasing and approved when necessary by the Corporation Executive Board or other authorized official. A three-part slip can be made, one for the person making the request, one for inventory control and one for the purchase order (See Exhibit 3, Sample Requisition Slip, page 8).
- **Purchase Orders** - Use of purchase orders helps to identify the purchase, fixes a cost at the time of purchase and helps to avoid duplication of orders. They should be prepared by the employee responsible for purchasing. They are usually prenumbered and contain four copies: one for the person in charge of purchasing, one for the person making the request, one for inventory control and one for the vendor (See Exhibit 4, Sample Purchase Order, page 9).
- **Follow-up on Orders**–The person responsible for purchasing should file all purchase orders under the date of promised delivery. This allows the person responsible to keep track of delivery times and make any necessary calls to expedite delivery. Mutilated or cancelled purchase orders should be retained in the file.
- **Check the Shipment against the Purchase Order** - All orders should be checked at the time delivery for condition, quantity delivered, damage, price and verification that what was ordered was the item actually received. A copy of the verified receiving slip should be attached to the original purchase order and forwarded to the individual responsible for paying the bills. Once the invoice arrives, the individual responsible for paying the bills should compare the invoice to the receiving document, checking quantity and price. This procedure will assure that the bill represents the actual goods or services received.
- **Supply Inventory Control** - A record of all regularly purchased items should be maintained. An up-to-date record will not only show the supply on hand, but will assist in planning purchases and avoid shortages of materials.
- **Physical Inventory of Capital Equipment** - On an annual basis, all capital equipment should be physically counted and a listing prepared showing the original cost of each item. The original cost of equipment listed in the property inventory records should be compared and adjusted to the physical inventory. Missing items or deviations from the property inventory records should be reported to the Community Board.

EXHIBIT 1

SAMPLE CLEANING CHECKLIST

1. **Daily Tasks**
   1. Empty waste receptacles
   2. Clean and disinfect lavatories
   3. Replenish supplies
   4. Dry mop rooms, halls and waiting room
   5. Dust furniture
   6. Vacuum

S ,	M	T	W	T	F	S
Comments:						

2. **Weekly Tasks**
   1. Waxing of furniture
   2. Washing and waxing floors
   3. Remove fingerprints from walls, woodwork and doors

	1	COMMENT	2	COMMENT	3	COMMENT	4	ETC.
	1.		1.		1.		1.	
	2.		2.		2.		2.	
JULY	3.		3.		3.		3.	
	1.		1.		1.		1.	
	2.		2.		2.		2.	
AUG.	3.		3.		3.		3.	
	1.		1.		1.		1.	
	2.		2.		2.		2.	
SEP.	3.		3.		3.		3.	

3. **Monthly Tasks**
   1. Stripping and rewaxing of heavily traveled floors
   2. Washing walls
   3. Washing windows

J	F	M	A	M	J	J	A	S	O	N	D

4. **Yearly Tasks**
   1. Drapery/upholstery cleaning
   2. Stripping and rewaxing

The above list and time frames will need to be adapted to individual practice needs. Frequency of certain tasks will vary greatly depending on amount of traffic in practice.

EXHIBIT 2

SAMPLE FURNITURE AND EQUIPMENT LIST

Receptionist Work Area

- Reception desk and chair
- Filing cabinets for medical records and other supplies
- Adding machine (with a tape)
- Typewriter

Waiting Room

- Chairs (minimum of two chairs per exam room)
- Tables (several small tables)
- Lamp
- Magazine rack (for magazines and/or patient education material)
- Coat rack
- Children size furniture (if pediatrics is practiced)

Examination Room

- Exam table
- Stool
- Writing surface
- Storage cabinet
- Gooseneck lamp
- Paper towel dispenser
- Waste container

Physician's Office

- Desk and chair
- Bookshelves
- Two comfortable chairs
- Lamp
- Dictating Equipment (if dictation of medical records is anticipated)

EXHIBIT 2 CONT'd

Laboratory

- Small desk
- Storage cabinets with large working surface
- Stool(s) to accommodate working surface
- Microscope
- Centrifuge
- Incubator
- Refrigerator
- Chair for patients

Nurse's Work Area

- Scale (preferably upright)
- Desk and chair
- Autoclave
- Storage cabinets
- Baby scale

Utility Room

- Hamper
- Shelves (for storing dirty equipment)

Lavatories

- Paper towel dispenser
- Waste container
- Mirror

EXHIBIT 3

SAMPLE REQUISITION SLIP

DATE	ITEM	QUANTITY	DESCRIPTION

NAME _____

Signature

EXHIBIT 4

SAMPLE PURCHASE ORDER

PHONE 609-924-9073

To

Ship To

DATE	DELIVERY DATE	SHIP VIA	F.O.B.	TERMS	PURCHASE ORDER NO.
					NO. 1152

QUANTITY	DESCRIPTION	PRICE	AMOUNT

AUTHORIZED SIGNATURE

OUR PURCHASE ORDER NUMBER MUST APPEAR ON ALL INVOICES, SHIPPED PAPERS AND PACKAGES

THE
STAFF

4

INTRODUCTION

The success of any business operation is primarily due to the ability of that business to provide services and/or products satisfactorily and economically to its customers. This is no less true for a medical practice. Since the NHSC Community Board has the responsibility for the management of the practice, it is essential that the Board develop effective staff management procedures, and recruit and select personnel who will help you achieve the goals of your practice.

Your staff will be the primary communications link between the National Health Service Corps assignee(s) who will provide care, and the patients from your community who will receive care. Good staff management policies and procedures will help provide efficient and quality care for the patients who are served by the practice. This booklet was prepared under Contract no. HSA 105-74-211 by Family Health Care, Inc. 1910 K. St., N.W. Washington, D.C. 20006.

THE STAFF

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DETERMINING YOUR STAFF NEEDS

Prior to the selection of staff for the medical/dental practice, it is imperative that the group sponsoring the NHSC program set the goals for the practice.

Why is it important to establish goals before choosing your staff?
The goals that you set for your practice should be responsive to the needs of your community. Once stated they will also determine the personnel and finances required to achieve them.

What steps should be followed in planning and setting your goals?
- Determine population (volume of patients) to be served.
- Determine kinds of health services that are needed by this population.
- Consider how your health facility will interact with other health services available in your community.
- Consider what finances you have available to provide the services that you feel are needed.

Once you have researched the above areas, you will have a clearer idea of realistic goals that can be achieved in the operation of your health facility, and the number and type of staff members who will be needed in order to help you reach your goals.

These goals should be discussed with prospective NHSC assignees and staff, and will become an integral part of your Principles of Practice (See the Practice Policies Booklet).

ESTABLISHING A STAFFING PATTERN

A staffing pattern is a plan which indicates the number and kinds of physicians, dentists, and staff members that you will need to operate your practice. It is important to plan your staffing pattern carefully.

Why design a staffing pattern?
The purpose of a staffing pattern is to provide assurance that the health services desired will be available.

What are the considerations in formulating a staffing pattern?
Following are factors which should be considered in the design of your staffing pattern:
- The goals you have set.
- Estimated number of patients to be seen daily:
  - ☐ At initial start-up stage
  - ☐ As the practice grows
- The projected budget (See NHSC Guidebook Number 2, The Preoperational Budgeting Process)
- The number of providers that you have available.
- The kind of health services needed by community.
- The preference of the Physicians/Dentists in type of support personnel needed.
- The kind of health services needed by the community.

Tips to consider:
- General rules used in determining the required number of support staff are:
  - ☐ A physician can usually manage 1,000 to 2,000 active patients.
  - ☐ To accomplish this, a physician generally requires 2-3 staff members for support.
- Locate a practice that is similar to your projected operation, then observe the on-site tasks performed and who performs them. This can be helpful in determining your own staff needs and in establishing the initial staffing pattern.

Remember that adding staff members as the practice grows is much easier than terminating staff members because of inadequate planning.

FORMULATING JOB DESCRIPTIONS

A job description is a statement of the specific tasks to be performed by the individual filling a particular position (See Exhibit 1, Sample Job Descriptions, page 4).

Why are job descriptions necessary?
Job descriptions define the areas of responsibility and the tasks which need to be performed in each of these areas. They are necessary because they serve as a guide to the qualifications needed for each position and to define the staff member's role and responsibilities. Job descriptions can also be used as an instrument to evaluate staff performance.

What are the steps in the development of a job description?
- List all the tasks which need to be performed in descending order of priority for each individual position.
- List the personality traits required to perform effectively in each position.
- From the task list and personality traits required, abstract the qualifications needed for each position.
- Set a salary range for each position. This should be consistent, and competitive, with similar skill levels in your employment area.

RECRUITING, SELECTING AND HIRING THE STAFF

A recruitment program is an organized procedure for advertising and interviewing prospective candidates for your staff. Good recruitment tactics are important to help you fill positions with the most suitable and qualified personnel.

What are the elements in an effective recruitment program?

- Advertise the position accurately - this will help insure that you will get responses from individuals who are truly qualified for the position.
- Use a good application form (See Exhibit 2, Sample Job Application Form, page 6).
- It is a good idea to have several individuals interview all applicants for a position. If possible, at least one of the individuals conducting the interview should have functioned in a similar position. All individuals conducting the interview should clearly understand the qualifications, skills and personality needed for the job.
- When interviewing prospective personnel, give each applicant a clear picture of the job requirements, responsibilities, benefits, and hours of work.
- Check references (at least two).
- When you have made a decision, the accepted applicant should be informed as soon as possible. All others should be notified that the job has been filled.

Remember - the Equal Employment Opportunity Act requires every employer to make employment decisions on a nondiscriminatory basis. Every Community Board must adhere to the following provisions:

> "The Community Board (sponsor) certifies that it does not now, and assures that it will not in the future, discriminate on the basis of race, creed, sex, color, age, national origin, religious beliefs, physical handicap, marital status, ancestry or liability for service in the Armed Forces of the United States, or have any interest to make any limitation, specification or discrimination, unless based upon a bona fide occupational qualification. The Community Board agrees this provision against discrimination will be carried out by the applicant as the primary contractor or by any subcontractor or other supportive agencies or parties. NHSC personnel will not be used, directly or indirectly, in any situation wherein care is provided in a discriminatory manner. The Community Board will take all action necessary to determine if prohibited discrimination exists, whether directly or indirectly, and will report promptly to the National Health Service Corps any such discrimination. Each unit will provide the National Health Service Corps access to all records and other information deemed necessary by the Corps to ascertain compliance with this Section. The applicant will comply with all federal, state and local laws and regulations regarding employment, wage rate, taxes, disability and unemployment insurance and other programs required by employers in the locale."

MANAGING THE STAFF

The first step in effective management of a staff is the development of written personnel policies. Personnel policies explain staff responsibilities, working conditions, and the goals and objectives of the practice (See NHSC Guidebook Number 1, Practice Policies, Exhibit 4, Sample Personnel Policies and Procedures, page 18).

Why are Personnel Policies essential?

These policies provide basic statements which define your intent regarding personnel, and they help satisfy and provide the security needs which are important to employees.

How do you write Personnel Policies and Procedures?

- Formulate and write policy satements for your practice (See *Practice Policies:* Formulating Personnel Policies). These policies should be specific and provide guidance for day-to-day operations and procedures. Topics that should be addressed are:
  - ☐ Employee relations
  - ☐ Employment practices
  - ☐ Hours of work
  - ☐ Salary administration
  - ☐ Employees' benefits
  - ☐ Reasons for termination of employment
  - ☐ Employee grievance procedure

A staff orientation program should be planned and conducted for all new employees. This program should familiarize new personnel with the standard operations of your practice and acquaint them with the other personnel involved in the delivery of medical/dental care. Good orientation is an important factor in helping your staff perform effectively.

How are staff orientation sessions planned?

- Identify individuals who will be responsible for orientation.
- Stress the goals of the practice, i.e., kinds of care to be delivered that have been defined by the Community Board.
- Introduce your staff to each other.
- Explain to each staff member his/her responsibilities and specific job assignments and how their performance will be evaluated.
- Explain to each staff member the role and responsibilities of others on the staff.
- Explain the Personnel Policies and Procedures.
- Establish mechanisms for answering staff members' questions concerning any aspect of the practice which they may not understand.

Once you have organized a staff there will then be a need for supervising and managing personnel. This is an important function which must be consistently and conscientiously monitored by members of the Community Board.

Why is it important for the Community Board members to assume the overall responsibility for the supervision and management of the staff?
The Board, as the sponsor of the NHSC program, is vested with the ultimate responsibility for each management function of the medical/dental practice. Supervision of the staff is one of the most important management responsibilities, therefore the Board must have assurance that staff performance is regularly reviewed by designated individuals.

What are the keys to good staff management?

- Separate responsibilities.
  - ☐ Matters involving medical problems or decisions should be controlled by the physician/provider in the group.
    Administrative functions and nonmedical decisions may be handled by a Board member or, in a larger practice, by an office manager.
    Where an office manager is not required, the community coordinator or another member of the Board should be designated responsible for:
    Overseeing personnel
    Communicating Board decisions regarding personnel to staff members
    Hearing and processing personnel grievances which may arise.
- Set up good staff communication.
  - ☐ The staff meeting is the simplest way to transmit information. Each person should have the opportunity to express his/her understanding of what has been discussed. These meetings should be scheduled on a regular basis (weekly or biweekly).
  - ☐ Continuing education discussions are another way to facilitate staff communication. Meetings should be well planned for content and length of time.
- Tools used in staff management should include:
  - ☐ Personnel procedures and job descriptions.
  - ☐ Clear delegation of responsibilities.
  - ☐ Supervision in areas where there are three or more persons.
  - ☐ Written and/or oral staff evaluations every 6 or 12 months.

After you have recruited, hired and trained an effective staff, it is important to keep them motivated and satisfied with their work. If there is dissatisfaction among staff members or lack of motivation, the efficiency of your practice will be impaired, and a rapid turnover of personnel may occur.

What are some factors essential to employee job satisfaction?
Studies have shown that the factors employees rated most highly as important to job satisfaction are:

- A feeling of accomplishment.
- An opportunity to use their abilities.
- An opportunity to advance abilities.
- Interesting work.
- Fair salary.

The manager or Board member in charge of personnel should periodically meet with each employee, individually, to review performance and discuss the above factors.

EXHIBIT 1

SAMPLE JOB DESCRIPTIONS

RECEPTIONIST

Responsibilities:

1. Greets patients and visitors, screens calls and visitors; arranges appointments and referrals.

2. Prepares new records, pulls, refiles, and maintains records.

3. Types correspondence, reports, memos, forms; transcribes medical notes (when applicable).

4. Performs billing and bookkeeping functions, such as: collects cash payments, posts and balances daily sheet of transactions, makes bank deposits, prepares and mails statements and third party claims, and inventories and orders office supplies.

5. Assists in office hour emergencies to keep communications open between clinic, hospital and possible accident scene.

Personality traits:

1. Should be able to work well under pressure.

2. Should have the ability to communicate well with people.

3. Can be trusted with confidential information.

4. Can act as a liaison between patients and physicians.

Qualifications:

1. High school graduate or vocational high school or high school equivalency.

2. One year of experience in clerical work preferred.

3. Ability to comprehend established office routines and regulations; learns quickly from oral and written instructions; ability to keep simple financial records and perform simple mathematical tasks.

4. Good health.

EXHIBIT 1 Cont'd.

HEALTH AIDE

Responsibilities:

1. Performs basic nursing duties under supervision of physician or registered nurse or licensed practical nurse.

2. Collects and records defined data base.

3. Prepares and cleans supplies and treatment area.

4. Receives patients, pulls and refiles medical records; takes limited medical histories.

5. Handles telephone, mail, appointments.

6. Participates in health care team conferences.

Personality traits:

1. Ability to communicate comfortably with people.

2. Can be trusted with confidential information.

Qualifications:

1. Ability to comprehend established office routines and regulations; can learn quickly from oral and written instructions.

2. Good manipulative skills.

3. Good health.

EXHIBIT 2

SAMPLE JOB APPLICATION FORM

Name _____
First Middle Initial Last

Address _____
Street City State Zip

Phone _____
Home Business

PREVIOUS EXPERIENCE

1. **Dates of Employment** _____ **to** Present _____

Place of Employment _____
Name of Business Address

Position Title _____

Description of Responsibilities _____

Salary $ _____ **per** _____

Average hours per week _____

Name of Immediate Supervisor _____

Tele. # _____

Area Code # _____

2. **Dates of Employment** _____ **to** _____

Place of Employment _____
Name of Business Address

Position Title _____

Exhibit 2 cont.

Description of Responsibilities _____

Salary $_____ **per** _____
Average hours per week _____
Name of Immediate Supervisor _____ **Tele. #** _____
Area Code # _____

3. **Dates of Employment** _____ **to** _____
Place of Employment _____
Name of Business Address

Position Title _____
Description of Responsibilities _____

Salary $_____ **per** _____
Average hours per week _____
Name of Immediate Supervisor _____

Tele. # _____
Area Code # _____

EDUCATION

4. **Highest Grade Completed** _____
5. **Degrees or Certificates** _____
Degree Place Year received

OTHER

1. **Fluency in language other than English** _____
Yes No

If yes, what language _____

2. **Other skills** _____

_____

3. **Honors and Awards** _____

_____

REFERENCES

List 3 persons, who are not related to you, who have definite knowledge of your qualifications and fitness for the position for which you are applying. Do not repeat names of supervisors.

Full Name	Present Business or Home Address	Phone No.	Business or Occupation
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

THE
FRONT DESK

5

INTRODUCTION

The front desk, or the receptionist work area, is the center of activity in any health facility. The appointment system, billing, patient information, referrals and medical records are all handled by personnel working in this area.

Your patient's first contact in the practice will be with the front desk staff. After the patient receives care, then he/she returns to this area for billing and referral information. Therefore, the performance of your staff and the procedures you have established for use at the front desk can be of considerable importance in the success or failure of your practice. This booklet was prepared under Contract no. HSA 105-74-211 by Family Health Care, Inc. 1910 K. St., N.W. Washington, D.C. 20006.

THE FRONT DESK

5

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SELECTING A RECEPTIONIST/ BOOKKEEPER

Top priority should be placed on hiring a qualified, and preferably, experienced person for the position of receptionist/bookkeeper.

Why is this such an important job?
The receptionist is your practice's first contact with the patient. If the person in this position also functions as a bookkeeper, then he/she will also be responsible for the billings and collections.

What qualifications and characteristics should you look for when selecting a receptionist/ bookkeeper?
The individual chosen for this very important job must be able to communicate well with patients, as well as with other members of the staff. The receptionist/bookkeeper must have the ability to request confidential information tactfully and handle it discreetly. Since this position is often demanding, the individual selected must also be able to remain cool under pressure. Some of the responsibilities that a receptionist should be qualified to handle are:

- Welcoming patients and visitors
- Screening calls
- Arranging appointments and referrals
- Preparing, filing and maintaining of medical records
- Typing correspondence, reports and medical notes
- Assisting in office hour emergencies to keep communications open between clinic and hospitals
- Acting as a liaison between patients and provider(s)

If the receptionist also has bookkeeping responsibilities then he/she must also:

- Prepare and file third party claim forms
- Handle billing and collections
- Order supplies
- Pay bills

The receptionist holds a responsible position. He/she should be trained in the areas described above before your center opens, and paid a salary commensurate with past experience.

SETTING UP AN APPOINTMENT SYSTEM

An appointment system is an orderly method of scheduling patients with the personnel most capable of handling their problems.

Why is it important to maintain an appointment system?
It minimizes waiting time for patients, maximizes staff time and controls patient flow. An appointment system is essential if a practice is to function smoothly.

How do you plan an appointment system?
The first step in planning the appointment system is the scheduling of definite office hours. A staff schedule should then be developed to insure adequate personnel coverage during the office hours. An appointment scheduling book designed for the number of providers in your practice should then be purchased. Most office supply stores have a selection of appointment books suitable to a medical/dental practice. (See Exhibits 1 and 2, Sample Appointment Sheets, pages 4 and 5).

The provider should determine the appointment system and the amount of time required for each type of visit. The conventional method of scheduling appointments used by a majority of providers is the unit time method. This allows 10-15 minutes for a routine office visit, 15-30 minutes for an extended office visit and 30-60 minutes for a complete physical examination, and appointments are scheduled on the quarter or half hour accordingly. An alternate method which has received some interest is a "modified wave" system in which patient appointments are grouped. (See Exhibit 3, "Modified Wave" System, page 6).

Time allocations are usually contingent upon the following factors:

- Provider's style of work
- The patient's problem
- Type of service to be rendered

Remember - it is very important to inform your community that your practice functions on an appointment basis. This will minimize the number of "walk-in" patients and cancellations. There may be a few patients who will not adhere to this policy, and to serve them the provider may choose to set aside one hour during the day to fit these patients into the schedule. Of course, emergency cases must take priority over routinely scheduled patients.

ESTABLISHING A GOOD RELATIONSHIP WITH PATIENTS

Specific procedures should be initiated to establish a good patient-practice relationship. Patient satisfaction is the key ingredient in expanding your practice. The front desk personnel play an important role in forming the patient's impressions about your practice and its services.

What can be done to establish a good relationship with the patients?

- Smile! A friendly greeting should be extended to each patient.
- Address the patient by name whenever possible.
- Explain scheduling procedures, the appointment system, office hours, and rules of the practice to new patients.
- Answer any questions the patient might have.
- When patients call for an appointment, encourage them to state the nature of their problems. Determining the reason for the call will assist in allocating sufficient time when scheduling the appointment, and help to reduce unnecessary waiting.
- When a patient has to wait more than fifteen (15) minutes, reassure the patient that the provider will be available soon.
- Be discreet when patient problems are discussed and make sure that the conversation cannot be overheard by the other patients.
- When obtaining patient registration information (age, method of payment, marital status, etc.), do so in a manner that ensures confidentiality.
- After the patient's visit is completed, be certain that he/she understands any instructions for referrals, date and time of return office visit and the fees charged for the services rendered. Also determine the method of payment.

MAINTAINING EFFICIENT PATIENT FLOW

Patient flow is the physical movement of patients from their point of entry into the practice to the point of exit. This should always be accomplished in an orderly and efficient fashion.

Why is efficient patient flow important?
If patients move efficiently from point to point in the practice, it increases their satisfaction, enhances provider productivity and saves wear and tear on the staff.

How do you plan and maintain efficient patient flow?

- Keep heavily trafficked areas free from any obstacles
- Make sure hallways are wide enough to handle two-way traffic
- Keep exam rooms in continuous use
- Place the registration and billing area away from the central traffic pattern to allow for confidentiality
- Insure that equipment and supplies are easily accessible to the personnel who will use them
- See that the medical record and encounter form/fee slip accompanies the patient to the provider of care
- At the beginning of each day give the provider a copy of the day's appointments
- Allow sufficient time to insure that the provider is able to respond fully to the patient's problems
- If there is a frequent backlog of patients or treatment delay, review and reevaluate the appointment system and make appropriate adjustments.

HANDLING REFERRALS

Most practices do not provide all health services needed by the patient and consequently patients are referred to other health sources for the type of care they require. The receptionist will usually schedule referrals.

Why should the receptionist handle referrals?
The receptionist answers patient questions, schedules return office visits, and is the last point of contact for the patient. Thus, the receptionist should have all referral information available for patient use.

What kind of referral information should be available to the receptionist?
The provider, with the help of Community Board members, should establish linkages or referral points for those services not available within the practice. Once these linkages have been established, a formal list of referral points should be made for the receptionist. This should include information about the following:

- Hospitals
- Laboratory services not available in the practice
- X-ray services not available in the practice
- Specialists in areas not covered by the practice
- Extended care facilities
- Ambulance/rescue squad

Information on each referral point should contain the name of a contact person, address, telephone number, hours of operation, general fees and admission procedures for in-patient facilities, and a description of the procedures necessary for insuring feedback to the practice from the referral point.

If a referral is indicated, the receptionist should schedule it according to provider instructions and patient convenience.

OBTAINING INFORMATION ON NEW PATIENTS

During the patient's first visit to the practice, basic information should be gathered. The information should include both medical history and data the practice may need for billing purposes. This information must be collected to insure proper patient care and maintain an efficiently run practice.

How can this information be collected?
The following forms should be developed and utilized:

A Registration form (See Exhibit 4, Sample Registration Form, page 7). This form should contain:

- Patient name
- Address
- Telephone number - home and business
- Sex
- Date of birth
- Name of individual responsible for payment of the bill
- Account number for billing purposes (to be assigned by the receptionist/bookkeeper)
- Medical record number (if this is different from the account number)
- Name of Health Insurance Carrier
- Name and address of employer
- Names and birthdates of other family members

The original registration card should be filed and maintained by the receptionist for billing/collection purposes. A duplicate copy should become a permanent part of each patient's medical record jacket.

Medical Information Forms:
The receptionist should assemble in advance the forms selected by the provider(s) for standard use in the medical record. The patient's name and billing account number should be entered on the medical record so that this information is easily seen. Allergies and sensitivities should be clearly identified on the front of the medical record and any routine medication should be noted.

Consent Form:
The written consent of the patient should be obtained for the release of medical information from previous providers. The name, address and phone number of past providers should be included on the consent form. The consent form, accompanied by a cover letter, should then be sent to the previous provider(s) (See NHSC Guidebook Number 6, The Medical Record, Exhibit 11 and 12, page 13).

BUILDING FRONT DESK EFFICIENCY

Front desk efficiency is the result of smooth and orderly operation of all activities conducted by the staff in this area. It is critical to maintain order at the front desk to insure that patient satisfaction will be achieved, provider productivity will be increased, effective flow of information between patient and provider will be maintained and billing and collection procedures will be efficiently executed.

What steps can be taken to achieve front desk efficiency?

- The provider and Board should define, in writing, the responsibilities that the receptionist should assume
- The Community Board and the provider(s) should jointly determine, and commit to writing, all practice policies for the receptionist's use. For example: credit policies, billing policies, appointment systems, office hours, coverage schedule for non-office hours, fee schedule, standard referral points, procedures to follow in emergencies during both scheduled and unscheduled office hours, and grievance procedures for patient complaints.
- Organize equipment and supplies so they are convenient and accessible to the receptionist.

The Telephone
Since the receptionist has the primary responsibility for answering the telephone, the phone should be conveniently located in the receptionist work area. Sufficient additional lines should be installed (along with a hold button) to accommodate the needs of the practice, plus an intercom or interoffice communications system. In a large group practice, an unlisted telephone number might be considered in addition to the listed numbers so that the provider(s) will always have access to an open line. Remember to provide the receptionist with telephone message slips to be used for all incoming calls (See Exhibit 5, Sample Telephone Message Slip, page 8).

An Adding Machine
If the receptionist is responsible for the billing and collections, he/she will need an adding machine.

A Typewriter
A typewriter should be conveniently located for the receptionist's use.

Billing Equipment and Supplies
If the receptionist is responsible for billing patients, then it is important that the following billing supplies and equipment be located at his/her desk:

- fee tickets/encounter slips
- deposit slips
- statements/ledger cards
- addressing materials (labels, envelopes, stamps)
- supply of insurance forms most commonly used with instructions (Blue Cross/Blue Shield, health insurance claim forms or third party carriers' forms that are prevalent in your area)
- supply of Health Insurance Claim forms which are accepted by most third party insurance carriers (See Exhibit 6, Sample of Approved Health Insurance Claim Form Page 9).
- Medicare and Medicaid forms and instructions for use.

For practices using a standard pegboard system, the following additional equipment and supplies should be easily accessible to the receptionist:

- pegboard and supplies
- ledger card files
- daily log sheets

Medical/Dental Record Supplies
All medical/dental record forms and active patient records should be conveniently located for the receptionist's use.

EXHIBIT 1

DAILY APPOINTMENTS SCHEDULE

Provider Name _____ Date _____

	Patient Name	Record No.	Show	No Show	Walk In	Remarks
9:00						
9:15						
9:30						
9:45						
10:00						
10:15						
10:30						
10:45						
11:00						
11:15						
11:30						
11:45						
12:00						
12:15						
12:30						
12:45						
1:00						
1:15						
1:30						
1:45						
2:00						
2:15						
2:30						

EXHIBIT 2

DAILY APPOINTMENTS SCHEDULE

Date _____ **Dr.** _____

Time	Patient	Problem	Acct. No.	Tel. No.	Remarks
7:00 a.m.					
7:15					
7:30					
7:45					
8:00					
8:15					
8:30					
8:45					
9:00					
9:15					
9:30					
9:45					
10:00					

EXHIBIT 3
"MODIFIED WAVE" APPOINTMENT SYSTEM

The following appointment schedule is known as the "modified wave" system. This system acknowledges the fact that each patient visit does not require an equal amount of time, and because of its flexibility, contributes to maximizing productivity. Each hour in the "normal office hours" day is treated as a separate entity, with provision for a variety of appointment types. See Examples attached.

Advantages are:

1. As in Exhibits 1 and 2, an appropriate schedule can be adopted to suit the doctor's pace. As the doctor becomes more familiar with his patients, and more efficient in treating them, a schedule can be modified to appoint more patients per hour, thus increasing productivity.
2. The Receptionist or Appointment Secretary gains confidence in making appointments because she (or he) can place short visits in short time slots and longer visits in others. This complements the institution of receptionist protocols and facilitates receptionist training.
3. It is less likely to cause patient delays, because there is a built in "catch up" time at the end of each hour.
4. If the first appointments in the hour proceed smoothly, the physician may have time at the end of the hour for textbook reference, reviewing test results, dictating, returning phone calls, or even a cup of coffee.

"Special Appointments"

The doctor may wish to reserve blocks of time for purposes other than routine office visits.

1. **Physical Examinations.** You may wish to reserve three mornings a week for complete physicals, scheduling one per hour. Or perhaps the doctor may wish to schedule one complete physical each morning, or early in the afternoon. In any case, these examinations require special consideration when constructing your appointment system. Keep in mind that during the first few months of operation the majority of patients will be new to the practice and you will be doing more complete exams. Utilization of other staff during these hours should be considered.
2. **Special Telephone Hours.** Some doctors find it efficient (and well received by their patients) to set aside a specific hour or period of time each day to receive or return phone calls from patients requesting medical advice. This period may be scheduled at any point in the day, but is constant from day to day, and the time is well publicized. This technique is an effort to discourage patients from making random calls at all hours of the day (and night), and to increase their likelihood of speaking directly with the doctor, or receiving a more prompt reply to their inquiry. If the calling period is during regular office hours, the calls are screened by a nurse or paramedical person, prior to being passed on the to doctor.

Outgoing calls in response to earlier questions, or to report lab results, etc. may also be made during this special "telephone hour."

EXHIBIT 3

EXAMPLES OF APPOINTMENT TIMETABLES

MODIFIED WAVE

Traditional	I	II	III	IV
9:00	9:00	9:00	9:00	9:00
9:15	9:10	9:05	9:05	9:05
9:30	9:20	9:10	9:10	9:10
9:45	9:40	9:20	9:15	9:15
10:00	10:00	9:40	9:25	9:20
10:15	10:10	10:00	9:40	9:30
10:30	10:20	10:05	10:00	9:40
10:45	10:40	10:10	10:05	10:00
11:00	11:00	10:20	10:10	10:05
etc.	etc.	10:40	10:15	10:10
		11:00	10:25	10:15
		etc.	10:40	10:20
			11:00	10:30
			etc.	10:40
				11:00
				etc.

EXHIBIT 4

PATIENT REGISTRATION FORM

Patient Name _____ Account No. _____

Address _____ Zip _____ Phone _____

Distance from Practice _____

Date of Birth _____ Sex _____ Race _____

Occupation _____

Employer _____ Phone _____

Who should be billed _____

Employer _____ Phone _____

Insurance _____ No. _____

No. of Family Members _____

Names _____ Ages _____

_____ _____

_____ _____

_____ _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____ Address _____

Phone _____

EXHIBIT 5

TELEPHONE MESSAGE SLIP

*For: _____

Date: _____ Time: _____ a.m. / p.m. Received By: _____

Caller's Name: _____

Phone No.: _____ Acct. No. _____

- ☐ Please Call Back
- ☐ Urgent
- ☐ At Your Leisure

Message:

- ☐ Short of Breath
- ☐ Sore Throat
- ☐ Cough
- ☐ Fever
- ☐ Chest Pain
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Abdominal Pain

+Reply: ☐ O
☐ N

- ☐ Call Patient
- ☐ Call Pharmacy
- ☐ Have Pharmacy Call

***Doctor** **+Who Should Reply: O=Office N=Nurse**

EXHIBIT 6
SAMPLE HEALTH INSURANCE COUNCIL CLAIM FORM

HEALTH INSURANCE CLAIM - GROUP OR INDIVIDUAL EXHIBIT VI — COMB - 1 (2/70)

PART A — **TO BE COMPLETED BY PATIENT (INSURED)**

Spaced for Typewriter - Marks for Tabulator Appear on this Line

PATIENT'S NAME AND ADDRESS | DATE OF BIRTH

INSURED'S NAME IF PATIENT IS A DEPENDENT

NAME OF INSURANCE COMPANY | POLICY NUMBER | INSURED'S SOCIAL SECURITY NUMBER

IF GROUP INSURANCE, NAME OF POLICYHOLDER
(i.e., Employer, Union or Association through whom insured)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS SERVICES AS DESCRIBED BELOW BUT NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGE FOR THOSE SERVICES.
SIGNED (INSURED PERSON) ▶ DATE

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.
SIGNED (PATIENT, OR PARENT IF MINOR) ▶ DATE

PART B — **ATTENDING PHYSICIAN'S STATEMENT**

1. DIAGNOSIS AND CONCURRENT CONDITIONS
(IF DIAGNOSIS CODE OTHER THAN ICDA* USED, GIVE NAME):

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES ☐ NO ☐ — PREGNANCY? YES ☐ NO ☐ — IF YES, APPROXIMATE DATE PREGNANCY COMMENCED. DATE

3. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES†	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE - IF USED (IF CODE OTHER THAN CPT** USED, GIVE NAME)	CHARGES
		A SUPPLY CAN BE OBTAINED BY WRITING TO:		
		HEALTH INSURANCE COUNCIL		
		750 THIRD AVENUE		
		NEW YORK, NEW YORK 10017		

TOTAL CHARGES ▶ $
AMOUNT PAID ▶ $
BALANCE DUE ▶ $

†O - Doctor's Office — IH - Inpatient Hospital — NH - Nursing Home
H - Patient's Home — OH - Outpatient Hospital — OL - Other Locations
*ICDA - International Classification of Diseases
**CPT - Current Procedural Terminology (current edition)

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.

5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☐ IF "YES" WHEN AND DESCRIBE:

7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK). FROM THRU

9. PATIENT WAS PARTIALLY DISABLED FROM THRU

10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

11. PATIENT WAS HOUSE CONFINED. FROM THRU

12. DOES PATIENT HAVE OTHER HEALTH COVERAGE? YES ☐ NO ☐ IF "YES" PLEASE IDENTIFY

13. I DO NOT ACCEPT ASSIGNMENT. ☐

DATE | PHYSICIAN'S NAME (PRINT) | DEGREE

PHYSICIAN'S SIGNATURE | TELEPHONE

INDIVIDUAL PRACTITIONER'S SS# | ALL OTHERS - EMPLOYER I. D. #
MUST BE FURNISHED UNDER AUTHORITY OF LAW

STREET ADDRESS | CITY OR TOWN | STATE OR PROVINCE | ZIP CODE

MEMORANDUM REGARDING DISPOSITION OF THIS FORM ON REVERSE SIDE

Approved by the Council on Medical Service, A.M.A. 2/70

THE MEDICAL RECORD

6

INTRODUCTION

The medical record is utilized by all members of the staff and serves as the informational source on patient problems, plans and treatment. It is also a communication tool among various staff members.

Since the medical record also legally documents the care given a patient, it is a vital element in the daily operation of your practice.

Your practice should have a medical record system which facilitates accurate data gathering and operates with a standardized format, and a filing system which assures efficient record retrieval. This booklet was prepared under Contract no. HSA 105-74-211 by Family Health Care, Inc. 1910 K. St., N.W. Washington, D.C. 20006.

THE MEDICAL RECORD

6

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SELECTING MEDICAL RECORD JACKETS

Although the jackets you purchase must be durable, there are other factors to consider when making your selection of the type of folder that will be used for patient records.

What factors affect the selection of jackets?
The type of jacket that will be most suitable for your practice will depend on the assignee's preference, the type of record system the assignee wishes to maintain, the size of your patient population, the community's budget, and the storage cabinets you will select.

How do you choose a jacket?
Any jackets selected must be durable because they are used frequently and must stand up under extensive wear and tear. Your assignee may have a definite preference as to the type he/she finds easiest to use. This preference should be considered before ordering a supply.

There are various types of jackets. Plain manila jackets are relatively inexpensive and can be altered to meet various needs. Some jackets have specialty features such as color coding, pockets of various sizes, or preprinted information. The specialty jackets are more expensive than the plain manila type.

Color-coded jackets are extremely helpful in large practices because they facilitate filing, and cut down the amount of misfiled records. Record jackets that have forms included in the price or have preprinted information are generally the "problem oriented" variety, and though more expensive initially, may include forms that you would have to purchase separately for record contents.

If you have selected standard file cabinets you will need a record jacket that has a top tab; if you are using open shelf lateral filing you will need a side-tab jacket.

It is advisable to visit local practices similar to your own to see examples of record jackets in use. Your local hospital may have a list of suppliers in your area.

DECIDING MEDICAL RECORD CONTENTS

The National Health Service Corps recommends the use of a Problem Oriented Record. The Problem Oriented Record has, as its focal point, each of the patient's problems. It reflects the logic of the provider in assessing and treating problems, while documenting the results. The patient's problems — their onset and resolution — are listed chronologically in the record.

Why is this record recommended?
The Problem Oriented approach standardizes the content of the record, systemizes the charting, organizes the method of identifying and recording a patient's problems, aids continuity between staff and providers, and facilitates retrieval of patient data quickly and accurately. In addition, it can help to improve patient care. The problem lists and medication lists, along with the progress note formats, provide a clear picture of the patient's problems for any provider using the record.

How is a Problem Oriented Record structured?
A chronic problem list is kept in the front of each record (See Exhibit 1, Sample Chronic Problem List, page 3). This list should have space for a problem number, the date the problem was identified, whether the problem is still active or resolved, and date of resolution. It should also have space for a standard coding number to identify the disease. Two lines for each problem allow space for updating the diagnostic level of the problem.

There should also be an Acute Problem List See Exhibit 2, Sample Acute Problem List, page 4) which has space for entering self-limiting problems and the dates of any recurrence of this problem. This can be designed with one line for each problem. The acute problems are identified with alpha symbols to distinguish them from the chronic problems which are identified by numbers.

A medication list is another important element (See Exhibit 3, Sample Medication List, page 5). It allows space to identify the problem for which the medication was prescribed, the medication itself, dosage, frequency, and the date started and discontinued. It also is referenced to the problem for which the medication has been prescribed.

The record should also include an allergy or sensitivity label (See Exhibit 4, Sample Allergy Label, page 5). This label can be affixed to the outside front cover of the record where allergies and sensitivities can be easily seen.

Another important element in a Problem Oriented Medical Record is the progress note (See Exhibit 5, Sample Progress Notes, page 6). These notes are kept in "SOAP" format. "S" is for subjective data: the symptoms or information related by the patient; "O" is for objective data: the vital signs, physical, laboratory or radiologic findings; "A" is for assessment: the physician's interpretation of the situation; "P" is for the plan of management.

Optional material that will make data collection more efficient includes:

Physiological Testing Data Sheet (See Exhibit 6, Sample Physical Examination Worksheet, pages 7 and 8). This is a standardized form organized by body system with space provided to record findings and results of the physical examination, and to record pertinent laboratory data. Items listed within each system will be determined by the specific defined data base of your practice. This form should be designed so that the practice can monitor the patient's health status over time.

Acute Illness Forms (See Exhibit 7, Sample Acute Illness Form, page 9). These are standardized mini-data bases specific to acute self-limiting problems. They facilitate screening, collection, and recording of treatment and follow-up. These forms save time in treating problems such as upper respiratory infections or gastrointestinal upsets.

Immunization Labels (See Exhibit 8, Sample Immunization Label page 10). This form provides a standard way for recording type and date of immunizations and boosters.

Chronic Illness Flow Sheets (See Exhibit 9, Sample Flow Sheet, page 11). These sheets are designed to graphically monitor chronic problems over time. They facilitate the recording of follow-up data and are arranged according to predefined parameters established by the practitioners.

Medical Record forms can be obtained through manufacturers of medical record systems. The community and assignee/provider should agree on the type of medical record forms, the amount needed, and the budget alloted for this purpose.

SELECTING A RECORD IDENTIFICATION SYSTEM

Each patient's medical record should be identified in a manner that will promote efficient and accurate retrieval and refiling.

Why is an identification system necessary?
A standardized method of filing and retrieval will assist staff members in working with patient files, and minimize misfiling.

What are the standard identification systems?
There are three basic systems of medical records identification: *alphabetic, numeric,* or *alphanumeric* (See Exhibit 10, Examples of File Identification Systems, page 12).

Records in an *Alphabetic System* are identified by the patient name. This type of file is used most often in very small practices (maximum of 4,000 expected patient population). It is only necessary to know the alphabet to successfully use this system and a cross reference file is not necessary. This system is hard to use if you have many families with similar last names.

Records in a *Numeric System* are identified by a number. The length of the number is determined by your maximum projected patient population (i.e., if you eventually expect to have over 9,999 patients you would set up a five digit number). Numbers are assigned to each patient record. This may be in straight numeric order (i.e., the first patient is assigned number 00001, the second, number 00002 etc.), or you may have specific numbers for special categories of patients (i.e., the 90000 series for Medicare patients and the 80000 series for nursing home patients). All numeric systems require a cross index file, so that you may look up the patient's name alphabetically in order to ascertain the correct record number.

Alphanumeric filing consists of combining alphabet symbols with numbers (i.e., John Smith would be SMI 6000). Usually the first three letters of the patient's last name provide the alpha segment of the identification and the numbers provide for orderly sequencing of the file system. This system, like the numeric system, requires an alphabetic cross reference file.

In both the numeric and alphanumeric systems it is possible to set up family numbers. The last number could identify a member of the family (i.e., John Smith, SMI 6000 - the father; Shelley Smith, SMI, SMI 6001- the wife; Kevin Smith, SMI 6002 - the first male child).

CHOOSING RECORD STORAGE

Medical records should be stored in an area convenient to the receptionist, yet not isolated from other staff members who must have access to the records for filing and billing. They should be placed so that they do not impede patient flow or present an obstacle to staff activity in the practice. Consideration should be given to selection of cabinets that will be most suitable to an efficiently run system.

Why is record storage important?
In a medical practice, records are used *often* by nearly all of the staff. The proper choice of cabinets and their convenient location will increase the efficiency of record handling.

How do you select a record storage cabinet?
Medical record cabinets used in a small practice are generally one or two types: *open shelf lateral files* or *standard drawer files*. Consideration of the following factors will assist you in the selection of the proper type of record storage for your practice.

Open shelf files require less floor space, are more convenient for personnel use, and are easily expanded as the practice grows. They can be purchased with shelves that slide out of a metal cabinet and have doors that may be locked to insure confidentiality. This type is generally more expensive than standard drawer files when initially purchased. Open shelves of wood or metal, which can be built by members of your community, might also be considered. However, records stored in open shelves are potentially susceptible to destruction, and loss of confidentiality could also be a problem.

Standard drawer cabinets, while less expensive initially than the open shelf type, make filing and retrieval a time-consuming task. When the drawers are open they require twice the amount of space of the actual cabinet and create a safety hazard. Drawers are very heavy, and when more than one is open, the cabinet may tip forward and seriously injure someone.

Other factors to be considered when purchasing filing cabinets:

- Check to see that files are constructed of fire proof material and have a locking device.
- When you choose a location for medical record storage, keep in mind the expected growth of your practice and leave room for expanding the storage area.

TRANSFERRING MEDICAL RECORDS

Many times patients will request that their medical record be transferred to another practitioner either because they are moving out of the area or simply because they have selected another practitioner. There may also be occasions when the assignee/provider will need to request a patient's medical/dental record from another practitioner. It is therefore important that your practice adopt a standard procedure for requesting and transferring medical/dental records.

If your relationship with the NHSC assignee/provider should terminate for any reason, it is also important to see to it that the medical/dental records are permanently stored in accordance with the existing state laws.

How do you transfer medical information?
If a patient or another provider should request that medical record information be transferred, it is essential that the patient sign a written consent form acknowledging that he/she wishes the release of medical information (See Exhibit 11, Sample Consent Form Letter, page 13).

How do you request medical information?
Once the name and address of the previous provider has been ascertained from the new patient, a letter and a patient consent form should be sent (See Exhibit 12, Sample Letter Requesting Medical Information, page 13).

What do you do with medical records if the assignee leaves?
There are various methods of transferring and storing the medical records. The Community Board should consult with a lawyer who is knowledgeable about the state laws pertaining to medical record retention.

If a private practitioner is available in the community, he/she might assume the responsibility for storage of the records.

If a private practitioner is not available to assume the medical/dental practice, it is important that patients be encouraged to let you know the name and address of the provider to whom their record should be transferred. In this case a patient should sign a release form for his/her records.

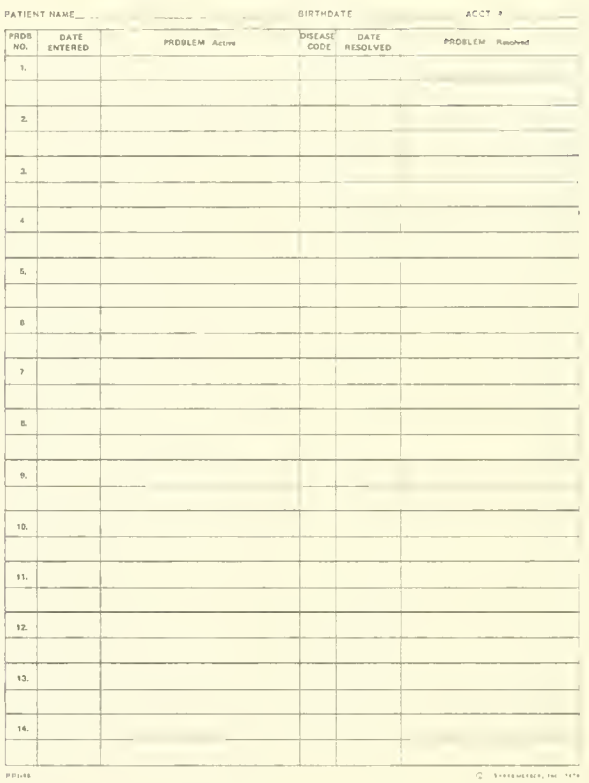
Another resource which might be helpful in providing information on the storage of medical/dental records is your local medical/dental society.

Generally, medical records of minors should be retained until they reach 21. Although the amount of time records must be retained for adults varies from state to state, it is usually necessary to retain records for at least a ten-year period.

Remember - storing medical/dental records is the responsibility of the Corporation sponsoring the NHSC program. If adequate storage space is not available in the practice, the Corporation may consider having the medical/dental records microfilmed, since the cost of renting additional space (over time) may be prohibitive.

EXHIBIT 1

SAMPLE CHRONIC PROBLEM LIST



PATIENT NAME_____ BIRTHDATE_____ ACCT #_____

PROB NO.	DATE ENTERED	PROBLEM Active	DISEASE CODE	DATE RESOLVED	PROBLEM Resolved
1.					
2.					
3.					
4					
5.					
6					
7					
8.					
9.					
10.					
11.					
12.					
13.					
14.					

EXHIBIT 2

SAMPLE ACUTE PROBLEM LIST

PATIENT NAME Smith, Shelley BIRTHDATE _____ ACCT. # SMI. 6001

PROB. NO.	PROBLEM	DATES OF OCCURRENCE 1	2	3	4	5	DISEASE CODE
A.	Sore throat	1/7/73	2/6/74				
B.							
C.							
D.							
E.							
F.							
G.							
H.							
I.							
J.							
K.							
L.							

EXHIBIT 3

SAMPLE MEDICATION LIST

MEDICATION LIST

PROB. NO.	MEDICATION	DOSAGE/ FREQUENCY	START DATE	STOP DATE
1	Methyldopa	250 mg qid	1/3/74	

PROB. NO.	MEDICATION	START DATE	STOP DATE

PPI-65

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EXHIBIT 4

SAMPLE ALLERGY LABEL

SENSITIVE TO:

1. PENCILLIN
2. _____
3. _____
4. _____
5. _____

672

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EXHIBIT 5

SAMPLE PROGRESS NOTES

Smith, Shelley January 3, 1975 SMI 6001

Date	Prob. No.	
2/1/74	1	HYPERTENSION S. Occasional occipital headaches, especially with emotional stress; one or two episodes of dizziness. Worries about having a stroke. O. Blood pressure 190/120, pulse 92, weight 198 (loss of 3 pounds), grade 1 retinopathy, A1 prominent but 4th ICS-MCL. A. No improvement in control of blood pressure--will stop Rauwolfia. This problem is probably related to number 1 and number 2. Rauwolfia may also be contributing to problem 5. P. Methyldopa 250 mg. qid. Continue weight reduction program. Return in 2 weeks.
2/1/74	2	HUSBAND ALCOHOLIC S. Patient complains husband abuses her and creates economic difficulties by constantly drinking, especially when at home. O. Husband does misuse alcohol, but drinks only at home. He is abusive in language only, and when drinking. Is very kind to children, does his job and is generally well liked. A. Husband's drinking is definitely related to patient's problems numbers 1 and 5. Patient unable to see her relationship to drinking problem, and husband seeking unrealistic solution to his emotional stress. P. Will try to get patient and her husband to accept counseling by marriage counselor and possibly AA, with other support as needed. May need temporary psychotropic drugs in either patient or her husband.

EXHIBIT 6

SAMPLE PHYSICAL EXAMINATION SHEET

PHYSIOLOGICAL TESTING – DATA SHEET

Name _____

Date of birth _____ Date:

Temp:

		R	L	R	L	R	L	R	L	R	L
Body Frame s m l Prad. Wgt. _____	Height (shoes off)										
	Weight/% pred.										
	Urine sugar/2° p.c. Bl. Sug.										
	PBI/Uric acid										
	Cholastarol/TriG										
	Sodium/Potassium										
ENDOCRINE	LDH/Chlorides										
	Calcium/Phosphorus										
	TP/albumin										
	SGOT/SGPT										
	Total lipid/B-Lipo Prot.										
	Vis. acuity										
EYES	Pinhole (20/40)										
Glasses yes no											
	Ocular tension (5.5 wgt.)										
	Steraopsis										
	Eyelids/pupils										
Color vision nl abn	E.O.M. (cover test)										
	Media (incl. lens)										
	Fundi										
	Pinnae/Canals										
	TM's										
	Hearing: (CPS) 500										
	(using oto- 1000										
EARS	cup without 1500										
	soundproof 2000										
	room. 3000										
	NL 20 db 4000										
	or less) 6000										
	8000										
NOSE	Airway/Septum										
	Lips/Tongue										
MOUTH	Gums/Teeth										
	Larynx/Pherynx										
	Carotids: bruit										
NECK	_____ pulsations										
	Thyroid										
	Nipples										
BREASTS	Masses										
	Symmetry										
	Peak flow/pred.										
	% pred. pf rate										
	M.E.F.R./pred.										
	% pred. M.E.F.R.										
LUNGS	Vit. Cap./pred.										
	% pred. VC										
	PX: (chest structure)										
	TBC Tine/IPPD										
	Chest X-ray										

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EXHIBIT 6 cont.

Name _____

		Date:									
		Technician's initial									
		R	L	R	L	R	L	R	L	R	L
C-V	BP (sitting)										
	Pulse per min.										
	PX: PMI/sounds										
	ECG										
Legs & Feet	Heart size (X-ray)										
	Varicas/calf circum. (cm.)										
	Dorsalis padis										
	Posterior tibial										
	Edema										
G-I	PX										
	Stool guaiec/rectal										
	Sigmoidoscopy (cm.)										
	GI/GB										
	Barium Enema										
	Billirubin/Amylase										
	Thymol/Alk. Phos.										
G-U	Pelvic/PAP (Fe)										
	Prostate/Genitalia (M)										
	IVP										
	BUN/Creetinine										
	Serology										
	Specific Grevity										
	Albumin										
	Microscopic										
	Colony count										
LYMPHATICS	Cervical										
	Axillary										
	Inguinal										
NEURO-MUSCULAR	Gait (tandem)										
	Romberg/Toes										
	Spaech/Tremor										
	Steps/Lift 6 lbs.										
	Coat/coin slot										
	Slippers on-off/Neck motion										
	Block test										
	Back: contour										
	DTR's: AJ										
	KJ										
	Babinski										
	Vib. sense (256) 2nd toe										
SKIN	Texture										
	Nodules										
	Eruption										
	Bruises										
PERSONALITY	Affect										
	Excesses										
	Depress. In. Score/Keys/L.C.										
HEMATOLOGIC	HGB/HCT										
	WBC										
	Smear										

EXHIBIT 7

SAMPLE ACUTE ILLNESS FORM

⊕ POSITIVE OR ABNORMAL ⊖ NEGATIVE OR NORMAL ☐ NOT APPLICABLE OR NOT EVALUATED

ACUTE ILLNESS FORMS

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CC: R L DURATION

EARS
- ☐ ACHE ☐ ☐ _____
- ☐ DRAIN ☐ ☐ _____
- ☐ > 3 INFECT./YEAR
- OTHER: _____

NOSE
- ☐ DISCHARGE/CONGESTION, ☐ > 2 WEEKS ☐ YEL./GRN > 1 WEEK ☐ BLOODY > 2 DAYS
- ☐ CHEEK/FOREHEAD ACHE: ☐ RIGHT ☐ LEFT
- ☐ NOSE DROPS - > 2 WEEKS

THROAT
- ☐ SORE THROAT: ☐ > 2 WEEKS ☐ SEVERE DYSPHAGIA ☐ > 4 STREP/YEAR
- ☐ SWOLLEN GLANDS ☐ > 3 WEEKS
- ☐ INSPIRATORY CROW/STRIDOR

NECK
- ☐ Hx "Rh" FEV. ☐ Hx HEART MURMUR
- ☐ RED/COKE COLORED URINE
- OTHER: _____

CHEST
- ☐ COUGH: ☐ < 2 WEEKS ☐ > 2 WEEKS ☐ SOB ☐ PLEURISY ☐ WHEEZE
- ☐ SPUTUM: ☐ CLEAR/WHITE ☐ BLOODY ☐ YELLOW: ☐ < 1 WEEK ☐ 1-2 WKS ☐ > 2 WKS
- ☐ ANKLE EDEMA (ADULTS) ☐ KEEPS AWAKE
- ☐ Hx: ☐ ASTHMA/COPD ☐ HT DISEASE

GENERAL
- ☐ MUSCLE ACHES ☐ FEVER: _____
- ☐ SHAKING CHILLS ☐ HEADACHE
- ☐ NAUSEA ☐ VOMITING ☐ DIARRHEA
- ☐ MEDICINE ALLERGY: ☐ PEN. OTHER: _____
- ☐ SMOKER
- ☐ PRIOR Rx: ☐ ASA ☐ ANTIBIOTICS ☐ COUGH MED.
- OTHER: _____

PE: R L

- ☐ DISCHARGE ☐ ☐ ☐ COLOR: _____
- ☐ CANALS ☐ ☐ _____
- ☐ T.M.'S ☐ ☐ _____
- ☐ MASTOID: TENDER ☐ SWOLLEN ☐ ☐ _____

- ☐ MEMBRANE: ☐ PALLOR ☐ INFLAMED
- ☐ POLYP ☐ PUS
- ☐ SINUS TENDERNESS: ☐ ☐
- ☐ ORBITAL EDEMA ☐ ☐

- ☐ TONSIL/PHARYNX
- ☐ SWELLING/EDEMA ☐ ☐
- ☐ INJECT. ☐ EXUDATE ☐ ULCER ☐ MEMB
- ☐ GLANDS: ANT. CERV ☐ ☐ _____
- ☐ POSTERIOR CERV ☐ ☐ _____
- OTHER: _____
- ☐ SPLEEN _____ ☐ EPIGLOTTIS _____
- ☐ HT. MURMUR: _____

- ☐ CHEST: ☐ RALES/RHONCH ☐ ☐
- ☐ WHEEZE ☐ ☐
- ☐ PEAK FLOW: _____/PRED: ____%: ____
- ☐ ANKLE EDEMA (ADULTS)
- ☐ RIB RETRACTION
- ☐ HEART.

- ☐ GENERAL APPEARANCE: ☐ NO DISTRESS
- ☐ UNCOMFORTABLE ☐ VERY ILL
- TEMP.: _____ PULSE: _____
- WEIGHT _____ RESP: _____
- ☐ STIFF NECK ☐ RASH

CHECK IF DONE: **RESULTS:**

- ☐ CULTURE _____
- WEBER: ☐ MIDLINE ☐ RIGHT ☐ LEFT
- ☐ EOSINOPHILE SMEAR: _____
- ☐ TRANSILLUM: ☐ RIGHT ☐ LEFT
- ☐ FRONTAL
- ☐ SINUS X-RAY: _____
- ☐ THROAT CULTURE: _____
- ☐ MONO SPOT: _____
- ☐ WBC: _____
- ☐ SMEAR: _____
- ☐ URINE S _____ A _____ CELLS _____
- ☐ CHEST X-RAY: _____

Rx:

- ☐ PEN VK 125-250 QID _____ DAYS
- ☐ TETRA 250 QID _____ DAYS
- ☐ ERYTHRO 125-250 QID _____ DAYS
- ☐ AMPI 125-250 QID _____ DAYS
- ☐ ORAL DECONG. ☐ COUGH SUP.
- ☐ GARGLE ☐ NASAL SPRAY ☐ MIST/STEAM
- OTHER: _____
- REFERRED TO: _____

PROBLEM: ☐ O.M ☐ OT EXT ☐ BR. PN. ☐ SINUSITIS ☐ BRONCHITIS ☐ INF. MONO ☐ PHARYNGITIS ☐ URI ☐ ALLERGIC RHIN ☐ BETA STREP ☐ RESP. FLU OTHER: _____

NAME: _____
DATE: _____

SEEN BY: AIDE _____ M.D. _____

RESPIRATORY

RETURN: SEE REVERSE

EXHIBIT 7 cont.

NOTE COURSE OF EACH SYMPTOM: ↑ BETTER, ↓ WORSE, NC NO CHANGE; N NEW

EARS DATE _____

SX: ☐ PAIN ☐ HEARING ☐ DRAIN ☐ FULLNESS
MEDS: ☐ COMPLETE ☐ STILL TAKING ☐ INCOMPLETE Rx
OBJ: ☐ CANALS: RT _____ LT _____
T.M.'S ☐ APPEAR: RT _____ LT _____
MOVE: ☐ RT ☐ LT
☐ MASTOIDS: RT _____ LT _____
☐ WEBER: RT _____ LT _____
ASSESS: DX _____ ☐ BETTER ☐ WORSE ☐ SAME ☐ RESOLVED
PLAN: _____
_____ ROV _____

EARS DATE _____

SX: ☐ PAIN ☐ HEARING ☐ DRAIN ☐ FULLNESS
MEDS: ☐ COMPLETE ☐ STILL TAKING ☐ INCOMPLETE Rx
OBJ: ☐ CANALS: RT _____ LT _____
T.M. ☐ APPEAR: RT _____ LT _____
MOVE: ☐ RT ☐ LT
☐ MASTOIDS: RT _____ LT _____
☐ WEBER: RT _____ LT _____
ASSESS: DX _____ ☐ BETTER ☐ WORSE ☐ SAME ☐ RESOLVED
PLAN: _____
_____ ROV _____

AUDIO DATE _____

500 R		L	3000 R		L
1000			4000		
1500			6000		
2000			8000		

REFERRED: _____

CHEST DATE _____

SX: ☐ COUGH _____ ☐ SPUTUM _____ ☐ CHEST PAIN _____ ☐ SOB _____ ☐ FEVER _____ ☐ MALAISE _____
MEDS: ☐ COMPLETE ☐ STILL TAKING ☐ INCOMPLETE Rx
OBJ: PEAK FLOW _____ CHEST X-RAY _____ TEMP. _____
☐ CHEST EXAM: RALES _____ WHEEZES _____
ASSES: OX _____ ☐ BETTER ☐ WORSE ☐ SAME ☐ RESOLVED
PLAN: _____
_____ ROV _____

THROAT DATE _____

SX: ☐ DYSPHAGIA _____ ☐ FEVER _____ ☐ MALAISE _____
MEDS: ☐ COMPLETE ☐ STILL TAKING ☐ INCOMPLETE RX
OBJ: TEMP. _____ ☐ MONO SPOT ☐ WBC _____ ☐ SMEAR _____
☐ PHARYNX. ☐ SWELLING/EDEMA _____ ☐ EXUDATE _____ ☐ INJECT.
☐ NECK NODES: _____
☐ OTHER NODES: _____ ☐ SPLEEN _____
ASSESS: DX _____ ☐ BETTER ☐ WORSE ☐ SAME ☐ RESOLVED
PLAN: _____
_____ ROV _____

PROBLEM: _____ DATE _____
SX: _____
_____
OBJ: _____
_____
ASSESS: OX _____ ☐ BETTER ☐ WORSE ☐ SAME ☐ RESOLVED
PLAN: _____
_____ ROV _____

EXHIBIT 8

SAMPLE IMMUNIZATION LABEL

	IMMUNIZATION	Initial Mo. Yr.	Booster Mo. Yr.
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

EXHIBIT 9

SAMPLE FLOW SHEET

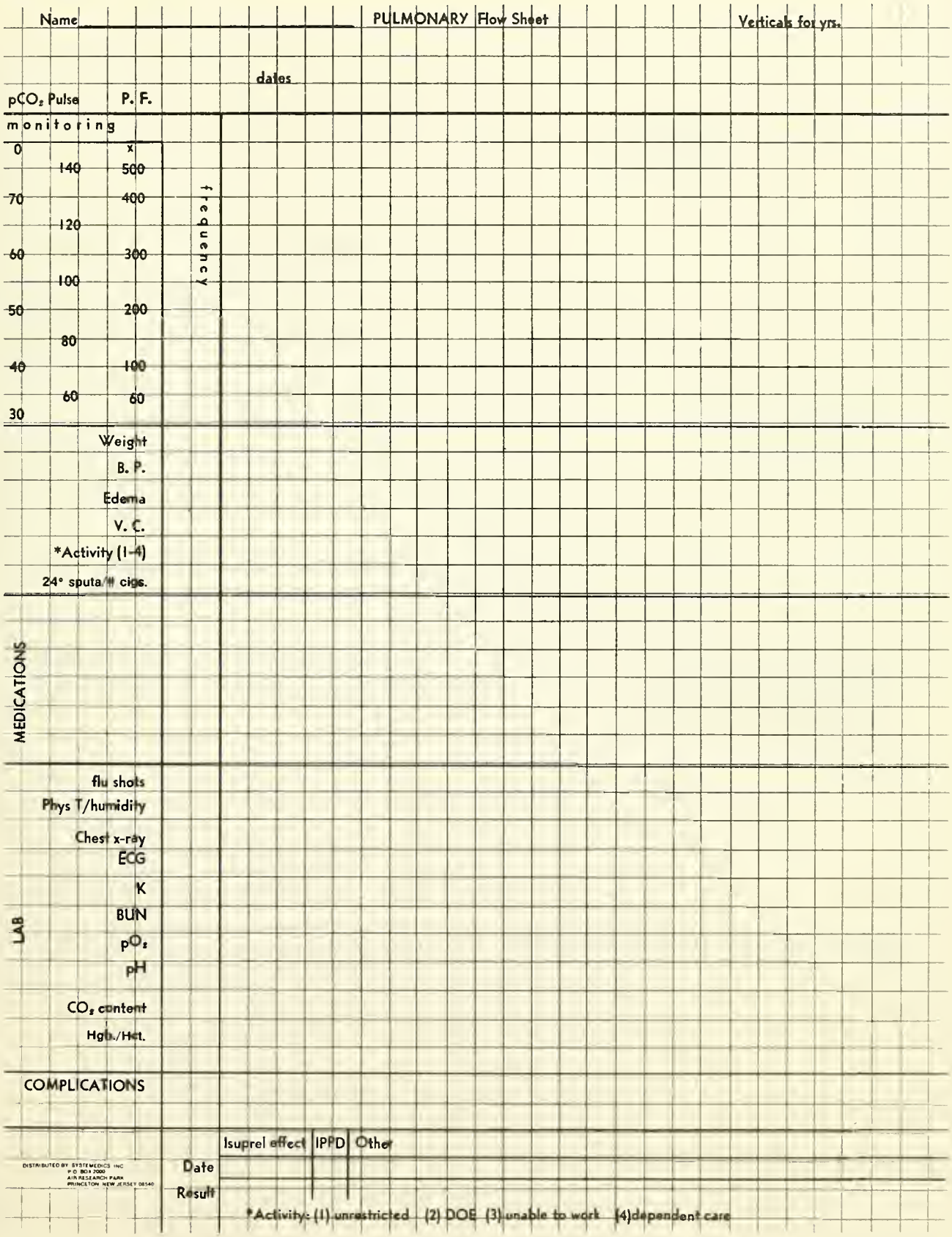

EXHIBIT 10

EXAMPLES OF FILE IDENTIFICATION SYSTEMS

A. Alphabetical:

Adams, James
Adams, Marilyn
Bruto, Gaye
Campbell, George

B. Numerical:

Name on Registration Card	Identification No. On File
Clark, James - 000001	000001
Dunlap, Gary - 000002	000002
Edward, Beth - 000003	000003

C. Alpha-numeric:

	Identification No. On File
John Smith (responsible party)	SMI 6000
Shelley Smith (dependent wife)	SMI 6001
Kevin Smith (son)	SMI 6002
Edward Smith	SMI 6010*
Martha Smith	SMI 6020*

---

*These represent responsible parties in other Smith families unrelated to John Smith.

EXHIBIT 11

CONSENT FORM LETTER

For Release of Medical Information

Date _____
Patient Name _____

I hereby authorize Dr. _____ to give to
(name of previous provider)
Dr._____ my complete medical file, including
(name of present provider)
medical history, lab reports, X-Ray, EKG, and/or any other material which pertains to treatment I have received.

Patient Signature _____

Previous Physician: _____
Name _____
Address _____
Telephone No._____
Area Code Number

EXHIBIT 12

SAMPLE LETTER REQUESTING MEDICAL INFORMATION

Date _____

Dear Dr_____
(previous provider)
A former patient of yours, _____ , has
(name of patient)
recently become a patient of mine.

Please send me the medical history of this patient and any other information you feel might be useful to me. A consent form, signed by the patient, is enclosed.

Sincerely yours,

Dr._____
(present provider)
Address_____
Phone No._____
Area Code No.

THIRD PARTY INSURANCE BILLING

7

INTRODUCTION

Regardless of the exact nature of the relationship, it is important that you, as providers of health care services, understand the general characteristics of the third party payors you will encounter. Through this knowledge you will be in a better position to intelligently structure those relationships and develop the type of internal procedures which will ensure that you maximize your return on an ongoing basis. This booklet was prepared under Contract no. HSA 105-74-211 by Family Health Care, Inc. 1910 K. St., N.W. Washington, D.C. 20006.

THIRD PARTY INSURANCE BILLING

7

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Establishing a Relationship	2
The Billing Process	3

DESCRIPTION OF THIRD PARTY PAYORS

The term "third party payors" is used here to describe the various governmental agencies, fiscal intermediaries and/or providers of health care insurance coverage who are involved to some extent in the payment of health care services.

For descriptive purposes, all of the third party payors may be placed into one of six categories. The following is a brief description of those categories:

1. **Governmental.** The most prominent are:
   - Medicare (also known as Title XVIII): This is a federal program administered by the Social Security Administration and intended to reimburse a portion of the medical cost incurred by individuals 65 years of age or older, regardless of income or ability to pay.
   - Medicaid (also known as Title XIX): This is a joint federal and state program administered by the state, and intended to reimburse health care providers their cost for services rendered to patients who are categorically needy. (This group includes children who are without the financial support needed to satisfy their health care needs, and certain handicapped individuals.)
     Depending upon the particular state, there may be a second group of individuals eligible for Medicaid benefits. This group includes individuals who have an income in excess of the poverty limit, but are deemed medically needy; i.e., their income is deemed insufficient to provide for adequate health care.

2. **Blue Shield.** Although technically not an insurance company, Blue Shield is probably the best-known provider of health and accident coverage.
   - Coverage
     Typically, a Blue Shield Plan (they vary widely, even within a single state) will cover the following services rendered by the practice physician: major and minor surgical procedures, obstetrical care and delivery, hospital visits, emergency care, and laboratory and X-ray services when performed in treatment of a medical problem (i.e., not when done as part of a routine examination).
     Rarely are the charges for physician's examinations in the office covered by Blue Shield. In some states Blue Shield does cover dental services and pharmacy services.
   - Provider "participation"
     Most physicians "participate" in their Blue Shield program. This means that they enter into an agreement to bill Blue Shield directly for covered services, and to accept the amount received as payment in full for those services. If the physician chooses not to "participate", the patient is billed directly for the services rendered and Blue Shield makes the payment to the patient. The amount of payment is the same regardless of whether or not the physician participates.

3. **Other health and accident programs.**
Practically every insurance company offers an array of individual and group health and accident insurance plans.

The range of physician's services covered may be great or small depending upon the patient's particular plan (i.e., not all of the patients with a particular brand of insurance will necessarily have the same array of services covered).

4. **Employers**
Another significant group of third party payors are employers, or their insurance company. A discussion of the primary forms which this relationship may take follows.
   - Workmens Compensation
     Most businesses carry insurance to cover the medical expenses associated with job-related medical problems (usually injuries) of their employees. The primary need on the part of the employer is a timely determination as to whether or not the problem was related to the job or preexistent.
   - Preemployment physical examinations
     It is a common practice for employers to enter into a contractual agreement with physicians to perform physical examinations for prospective employees. The purpose of these exams is to determine an individual's physical ability to perform the work in question, and to determine and document the existence of medical problems (even though they may not be severe enough to prohibit the employee from performing the work). As in the case of Workmens Compensation, it is important to the employer that the exam reports be forwarded in a timely manner.

5. **Unions**
Cost reimbursement arrangements on a preencounter basis between clinics and labor unions (such as the UMW of A) are common in certain sections of the country. Usually the reimbursement rates are negotiated on a quarterly, semiannually, or annual basis, and payments are made to the provider on a monthly basis.

6. **Life Insurance Companies**
Another type of contractual arrangement commonly encountered is that between a physician and a life insurance carrier for the performance of physical examinations of potential subscribers. The carrier's primary objective in securing these exams is to establish into which risk category the applicant is to be placed.

ESTABLISHING A RELATIONSHIP

1. The Initial Contact

One of the first things that should be done when it is known that a physician has been assigned to your community is to notify Medicare, Medicaid, and Blue Shield of this fact. These third party payors require the assignment of a physician identification number (often called a provider code) before any claims may be processed for services rendered by that physician. In order to accomplish this, it is usually necessary to provide the third party with the physician's full name, state licensure, and the name of the school the physician graduated from as well as the date of graduation.

2. Staff Training

Often, Medicare, Medicaid, and Blue Shield will offer instructional meetings for the business staff members, or assign field personnel to visit clinics to assist the staff in developing proper billing procedures. You should determine if and when these services are available so that your staff will have an opportunity to participate in these workshops, or so that a date may be set up for a meeting with the field representative.

The major third parties make available manuals or guide books outlining the accepted billing procedures and a schedule of the amounts which will be reimbursed, as well as the related procedure codes for the services rendered. If such a manual is not sent to you (usually with the initial supply of billing forms), it should be requested.

3. Accepting Assignment of Payment

As previously noted, when dealing with third parties you can elect to have payment made to the patient or to the physician. The amount paid in either case will be the usual and customary fees for your particular locale even if the fee charged is greater than this amount. If assignment of payment is accepted (i.e., the payment is sent to the physician), there is usually a provision that the patient will not be billed for the difference between the fee charged and the amount paid; the difference must be written off.

- Medicaid and Medicare
  In the case of Medicaid, assignment must be accepted. Due to an agreement between the NHSC and the Social Security Administration, assignment of payment must also be accepted for Medicare.
- Blue Shield
  The decision whether or not to participate in Blue Shield is up to you. It is important to note that if you choose not to participate, you still may elect to accept assignment on a case-by-case basis. Most physicians do accept assignment from Blue Shield because of its prevalence and because the scope of coverage and the amounts paid are well known. Blue Shield routinely provides physicians' offices with a manual specifying the recommended billing procedures and a listing of the services along with the amounts typically paid by them for those services.
- Other Insurance Carriers
  As for other insurance carriers, it is generally not advisable to accept assignment of payment. The same reasons most physicians participate in Blue Shield also cause them not to accept assignment with other third party carriers: the plans by and large are not prevalent; the scope of coverage is not well known; and the amounts reimbursed are unpredictable.
  One common exception to this is the *local* prevalence of one particular carrier where a large employer in the area carries a group policy that is other than Blue Shield.

4. Fees

The amount reimbursed by Medicare, Medicaid, Blue Shield, and most other third parties is based upon the "usual and customary" fee in your area for the service rendered. If your fee is greater than the amount reimbursed, then you must write off the difference if you have accepted assignment (with Medicare you must write off the amount "disallowed", but you may bill the patient for the annual deductible and 20% of the "allowed" amount).

- Fee Profile
  Most third parties make it a practice to maintain a "fee profile" of a physician's charges. This profile, or fee schedule, is often obtained from the physician at the time the relationship is established, or it may simply be developed over time as billings are received. The primary significance of this fact is that the third party will reimburse the physician based upon the "usual and customary" rate for the service, or the physician's own fee, whichever is less. This fact makes it extremely important that you develop a fee schedule which is adequate to cover your costs and yet within the upper boundaries dictated by the prevailing fees within your area.
  A good practice to establish is to update your fee profile annually with the various third parties. As your costs change, it is often necessary to adjust your fee schedule to reflect these changes. For example, during the past few years the cost of medical equipment and supplies increased sharply. Unless these changes are reflected in the fee schedule, the

relative profitability of the practice will be lowered. Therefore, it is important to inform the third parties with whom you have a regular relationship of these changes so that you will be eligible for a more favorable reimbursement rate when they adjust the "usual and customary" fees for your area. It is recommended that you consult the various third parties in your area to determine the procedures to follow in updating your fee profile.

- Reduced Fees
  One final comment is necessary regarding the fees billed to third parties. It is illegal to bill a third party at a different rate from an individual. In an NHSC setting this is sometimes confusing because the practice has agreed to apply a reduced fee to patients who meet a specified set of criteria for being "medically needy" (i.e., the family income is not sufficient, "as defined by a specific poverty standard such as the Social Security Administration", to provide entirely for the necessary medical services). The recommended practice in such an instance is to charge the patient the full amount, and simultaneously apply a credit adjustment in the amount of the reduction. By following this practice you will avoid the risk of someone interpreting the use of a reduced fee as the maintenance of multiple fee schedules.

THE BILLING PROCESS

1. Overview

In essence, the billing process for third parties is the same as for patients. In both cases a diagnosis is made, the same fee is charged, and assuming the patient does not pay at that time, a billing form is prepared and submitted. Once the bill has been sent, a system of following up on that bill must be established. When the payment is received, an entry must be made into the accounting system and the debt removed from the follow-up system.

2. An Example of a Third Party Billing Process

The billing process outlined below would be appropriate for use in a primary care setting with two providers who serve a population with a normal distribution of payments according to age and income. If your patient population does not conform to this model, or if you do not have a primary care practice, then the recommended procedures will probably not fit your needs. If this is the case, you should seek assistance in developing a billing process which will fit your needs.

Following is an outline of one possible set of third party billing procedures:

a. Gather the necessary registration information regarding the patient, such as the type of third party coverage and related numbers, date of birth, etc., and enter this information on a claim form before the patient is seen. If it is not possible to get this information before the patient is seen, then it should be obtained before the patient leaves the office. If a signature is required on the claim form, it should be obtained at this time. The partially completed claim form should then be attached to the clinic encounter form or charge slip.
b. The encounter form, claim form, and the medical record are then routed to the provider.
c. After the service has been rendered, the provider enters the service, fee, and diagnosis on the encounter form and the encounter form and claim form are routed to the reception area.
d. The cashier reviews the encounter form and claim form for missing information, and determines the amount to be billed directly to the patient, solicits payment, and records the encounter in the accounting system. The encounter form and the claim form are then forwarded to the billing clerk for completion and submission to the appropriate third party.
e. Within one working day of the encounter, the billing clerk will complete the claim form (i.e., enter the encounter information), and forward the claim to the provider for review and for signature if required. The provider should endeavor to return the completed claims to the billing clerk the same day that they are received.
f. Within two working days of the encounter, the billing clerk should submit the claim for payment. A copy of each claim submitted should be retained by the billing clerk for follow-up. It is recommended that these copies be filed alphabetically by month of service and payor (i.e., "July-Medicaid"), so as to facilitate follow-up.
g. If after 60 days payment has not been received, some form of follow-up action should be taken. A common procedure is to forward a copy of the delinquent claims to the third party accompanied by a memo requesting a statement from the third party as to the status of these claims. Experience has shown that practices which follow this procedure are often paid more promptly than those which do not.

COMMUNITY RELATIONS

8

INTRODUCTION

The interest and support of the people in your community will determine the success of your health care practice. The best staff and most dedicated provider of care still require the cooperation and participation of the community to build a successful practice.

Long before the NHSC assignee arrives, the whole community should be aware of the plans for your practice, and the type of health care and specific services which will be provided. When the practice opens, members of the community will want to know the provider of care and the goals of the practice. As the practice becomes operational the community residents will need to know the hours of operation, fee schedule, and methods of receiving services not provided by the practice.

The long term success of your practice will be determined by the extent to which members of the community utilize the NHSC provider. For these reasons, the NHSC sponsoring Board should develop an effective community relations program. This booklet was prepared under Contract no. HSA 105-74-211 by Family Health Care, Inc. 1910 K. St., N.W. Washington, D.C. 20006.

COMMUNITY RELATIONS

8

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INCREASING COMMUNITY AWARENESS

Your community should be aware of the establishment of a new practice, how it will function, and what services will be provided.

Why must the community be aware?
The number of patients that will seek services at your practice is directly related to the community's understanding of practice operation and how the services provided will benefit them.

How can you increase this awareness?
Enlist the cooperation of local newspapers, TV and radio stations. Through informational news releases or special programs, interviews or educational articles, you will be able to reach a large audience. Topics that might be of interest would include how and why the practice was organized, and what it hopes to achieve, what is being planned, and who is planning it.

Create pamphlets or leaflets for members of the community. It is a good idea to use a local professional printer to produce this material (See Exhibit 1, Sample Pamphlet, Your Health Center, page 3). Talk with local organizations. These should include PTA's, civic clubs and church groups. The talk should include a presentation and some visual materials. Use your pamphlet about the health center as something they can take home with them.

In addition, some of the following activities could be initiated immediately after site selection has been made. Install an outdoor sign at your facility location, "Future site of (name of health center), (planned opening date)". Set up a display at the local bank. This could be blueprints of the new facility or a photo of the facility being renovated. Any or all of these activities will help to raise community awareness, and encourage use of the health facility.

Remember - care should be taken that all materials and programs created for and about the facility be of an educational nature. Because of ethical considerations, plans for increasing community awareness, introducing the provider and the practice, and building patient volume *should not include anything that seems to advertise the facility or its services. This is extremely important.* For further information on guidelines in this area, please refer to *Opinions and Reports of The Judicial Council*, prepared by the American Medical Association and available from the AMA, 535 North Dearborn Street, Chicago, Illinois, 60610.

INTRODUCING THE PROVIDER AND THE PRACTICE

Plans should be made to acquaint the provider and the community with each other. The introduction should be carefully planned by the sponsoring Board well in advance of the provider's arrival in the community.

Why is this introduction necessary?
An introduction to the community affords the provider with an opportunity to become familiar with individuals, organizations and services in the community and, in turn, members of the community will be able to meet with the new provider and express their health needs.

How can introductions be made?
A good way to introduce both the provider and the new facility is to plan and hold an Open House. This will allow members of the community to meet the new provider and visit the facility at the same time. Initiate newspaper, radio or TV interviews with the provider(s). Include the provider in presentations before various civic and professional groups.

The provider will need communication with other health professionals; one good way to begin this communication is to plan a dinner for the new assignee and invite local physicians and/or dentists. This might be done several weeks after his/her arrival. You might also introduce the provider to the local medical or dental societies. The provider will need to establish contact with health services available in the vicinity. To facilitate this contact, formulate a list of names and phone numbers of any of the following specialists who may practice nearby:

General Surgeons
Pediatricians
Dentists
Neurologists
Ophthalmologists
Obstetricians
Orthopedic Surgeons
Cardiologists
Internists

Establish contact with any medical/dental college within reasonable traveling distance which might provide continuing education for the provider.

Also list the names and telephone numbers of the following ancillary services which are available locally:

Hospitals
Radiology
Nursing Homes
Emergency services
Laboratory
Pharmacy
Extended care facilities
Local Municipal/County Social Service Agencies

Physicians will need hospital privileges immediately. Arrange a meeting for them with physician members of the nearest hospital board.

Develop written communication about your practice before it opens. To introduce your practice, one-page announcements can be printed several weeks prior to the opening of your facility and distributed (or posted) in local commercial establishments such as drug stores, supermarkets, and banks. This announcement might include the date of the opening, name of provider(s), address of the health center, office hours and

a brief description of the type of services available (See Exhibit 2, Sample Announcement, page 4).

To introduce your facility and its staff once the practice is operational, a brochure should be printed describing members of the practice (Board, provider and staff), goals and objectives of the practice, type of care to be delivered (i.e., family practice, obstetrics, pediatrics, etc.), procedures of the practice and information for patients (See Exhibit 3, Tips in Planning a Brochure for your National Health Service Corps Practice, page 5, and Exhibit 4, Sample Brochure for Patients, page 6).

BUILDING PATIENT VOLUME

In order to insure the financial success of the practice, one of the goals of the sponsoring Board should be to build the volume of patients using the health center.

Why build patient volume?
An adequate patient volume is necessary for proper utilization of the provider and the staff, and for sustained financial success.

How do you build patient volume?
Establish good interpersonal relationships. This is an important element in any well-managed business. The Community Board and the provider should establish a working partnership through the Principles of Practice and agree, in advance, about such things as type of health services that will be delivered and hours of coverage. The Board and the provider will then be able to present a unified and informed image of the practice to the community. In addition, the staff must understand the practice and be able to communicate their knowledge to patients and members of the community.

Investigate other sources of income. Local companies and/or agencies often provide additional income for health centers. For instance, local industries may need a physician for either pre-employment physical examinations or industrial injuries. They may need a physician available part-time at their site, or to conduct annual examinations for their executives. Insurance agencies or companies might use the physician for physical examinations required for life insurance. Local schools may need mass screening health examinations. The local welfare office may need screening for an early detection and treatment program for children and mothers. Unions, farm cooperatives and/or companies may contract with the health center for health services to be provided for their members or employees. Since patient volume will build slowly, the sponsoring Board should explore all of these avenues to insure that the practice revenue can sustain the expenses.

Remember - the attitudes of the sponsoring Board members and the health center staff can affect the number of patients using the health center. The primary goal of health center personnel and Board members should be to make patients feel that they are getting the best possible health service in a relaxed professional atmosphere. If possible, Board members and the staff should also use the center for their family health needs.

In conclusion, inadequate patient volume has caused financial problems for many practices. For this reason, careful attention should be given to the steps taken to inform, educate and interest your community in the new practice. Remember that it takes time to build a successful medical practice, whether the practice is located in New York City or in a less populated area. The Board must be a responsive organization dealing realistically with problems of health care delivery, while at the same time advancing the legitimate self-interests of both community residents and providers.

To this end, the Board should recognize that any effort to organize health care delivery has to be a social enterprise in which everyone — providers and community residents — must be concerned about the final product: the well-being of the patient. Obviously, this means that providers should be able to work in a climate of personal and professional satisfaction. The patients must be the subject, not the object of the health care process. They should also participate, through the Board, in the advancement of their own well-being.

EXHIBIT 1

SAMPLE PAMPHLET

YOUR
HEALTH CENTER

582 Futter Street
Ardville, Nebraska

Telephone 893-7620

WHAT IS IT:	A center providing total family medical care.
WHO CAN USE IT?	Anyone.
WHAT DOES IT DO?	Total health care for adults and children. Physical examinations for insurance, camp, school, etc. Telephone answering service, 24-hour, 893-7620. Clinics: Well baby, mental health, planned parenthood. Referrals arranged with other agencies for special services, such as marital counseling, mental health, planned parenthood.
HOW DO I USE IT?	By appointment: Monday, 10-4; Tuesday and Wednesday, 9-4; Thursday, 1-8; Friday, 11-4. Walk-in for urgent problems only. Emergency patients should call the Center for advice (893-7620).

EXHIBIT 2 SAMPLE ANNOUNCEMENT

The Morgan County Health Council, Inc. is pleased to announce the arrival of Dr. Marilyn Mullin and the opening of the Morgan County Health Center on July 15. The Health Center will be located at 6226 Freeland Road, Jamestown, Wyoming.

General medical services will be provided and appointments can be made by telephoning 701-633-3162. Patients without appointments will be seen for emergency care only. In addition to general medical services, X-ray procedures and limited laboratory testing are available through the Health Center.

OFFICE HOURS:

Monday and Wednesday	9:00 a.m. - 12:00 p.m.
	5:00 p.m. - 8:00 p.m.
Tuesday, Thursday & Friday	9:00 a.m. - 5:00 p.m.
Saturday	9:00 a.m. - 1:00 p.m.

These office hours will be in effect for the next three months. A review will be conducted at that time to determine if these hours adequately meet the health needs of the community.

EXHIBIT 3

TIPS IN PLANNING A BROCHURE FOR YOUR NATIONAL HEALTH SERVICE CORPS PRACTICE

This brochure should be the introduction the patient has to your medical group. It is important that it is tastefully prepared, carefully written and brief. Use bold print for headings and leave enough blank space on each page so that the page does not appear crowded.

I. Purpose of booklet

- A. Goals and objectives of group
- B. Organization of group
- C. Procedures of group
- D. Information for patients

II. Brief description of

- A. Goals and objectives
- B. Community and physician (staff and Board should formulate this together)

III. Organization of group

- A. Physicians' names - specialists, if any
- B. Staff names
- C. Corporation president, etc.

IV. Procedures of practice

- A. Hours open for appointment
- B. What to do for emergencies - day and night
- C. Where help is available when group is closed
- D. Registration procedures - with whom to register, what to bring
- E. First visit procedures
- F. Appointment procedures
- G. Policy on house calls
- H. Confidentiality on medical records
- I. Release of information request
- J. Financial information - usual customary, RVS, posting of fees
- K. Billing procedures
- L. Insurance procedures

EXHIBIT 3 cont'd.

V. Information for patients

A. Appointments - how to make
B. On time for appointments
C. Cancellation of appointments
D. Change of address, name, phone number procedures
E. Insurance coverage
F. What they need to bring with them - if Medicare patients, other insurance forms
G. How and with whom to register a complaint

End the brochure with an expression of welcome to the patient.

EXHIBIT 4

SAMPLE BROCHURE FOR PATIENTS

PEMBROKE MEDICAL CLINIC

PEMBROKE TOWNSHIP COMMUNITY CENTER

PHONE 944-8811
If no answer
PHONE 933-7021

Dr. Allen Markowicz
Dr. Franklin Li

The Pembroke Clinic is a Problem Oriented Medical Information Service. Simply, it reflects a system of defining your health care needs, collecting necessary medical information and keeping records which enable us to constantly appraise what progress is being made. The "Clinic" in this case refers to a group of people, professional and especially trained non-professionals, working together to provide your health care.

The Clinic will provide defined standards of health care in several ways:

1) If you are "well" and desire preventive care, our service will be to obtain information about you and your health in a manner that will permit the detection of potentially dangerous problems before they adversely affect your health. The types of problems we look for and the frequency of testing will be determined by risk factors associated with your age and sex.

2) If you are "sick" and know that you have one or more medical problems, we will obtain the information necessary to manage those problems. In all cases, on the first visit, we will expect to perform a thorough examination to detect other potential problems about which you might not be aware, in the same manner as we would if you were "well". This may be done at the same time as we care for the original problem.

3) If you need care after office hours, one of the two physicians will be available. To reach him, call 933-7021, and the answering service will contact him and he will return your call. This is also true on weekends and holidays. This may not be the physician you usually see but he will be able to evaluate your condition with a few necessary questions including the names of the medications you are presently taking. He may tell you what to do over the phone, ask you to meet him in the hospital or ask you to come to the clinic the next day.

The Pembroke Clinic serves the medical needs of Pembroke and the surrounding area. Administratively, it is an agency of the Montgomery Community Action Program. The medical personnel are supported by the National Health Service Corps, a new branch of the United States Public Health Service. The purpose of the clinic is to serve the particular needs of Pembroke; therefore, policies are determined by the community, through the Pembroke Health Committee. Its members' names are available at the clinic.

The clinic is an attempt to correct the situation resulting from the community's inability to attract a doctor and the subsequent progressive neglect of its medical needs. It has been established to make medical care accessible to the community. It is hoped that if a real need evolves and a genuine desire to use medical services is demonstrated, a private practitioner will be attracted to the area in the future, or some other

accessible health care delivery system developed.

The National Health Service Corps pays the salaries of the medical personnel. It expects repayment of this expense insofar as this is possible. The community, specifically KCAP, pays for other operating costs. In order to attract a private practitioner, the community must demonstrate that it is able and willing to financially support a physician.

This is your clinic and all reasonable needs will be met as far as possible. Be sure to bring all medical information you have available and a list of medicines you are or have been taking recently. The clinic is open on weekdays from 9 a.m. to 5 p.m. except Wednesday, when it is open from 1 p.m. to 8 p.m. Hours will change as needed. Appointments are preferred - call 944-8811 during clinic hours. All persons are welcome, regardless of ability to pay.

Walk-in patients will be seen when time allows, or after all those with appointments have been seen. Of course, emergencies will be seen immediately. If you are unable to keep an appointment, please call and cancel your appointment in order that someone else can be given the appointment time. Please be considerate of your neighbors.

Services provided include:

1. General medical physical examinations
2. Treatment of general medical problems
3. Well-baby care
4. Uncomplicated pediatric problems
5. Immunizations
6. Laboratory tests
7. Minor wounds, suturing cuts, removing foreign bodies, etc.
8. Prenatal care
9. Family planning
10. Treatment at Riverside Hospital
11. Dispensing most common drugs prescribed by the clinic doctors
12. Obtaining necessary laboratory tests and delivering them to the laboratory in Montgomery
13. Screening test for anemia
14. Urinalysis
15. Electrocardiograms
16. Other disease screening programs as they become necessary

Finally, we believe that a well-informed patient is our most important assistant in providing good medical care. We will try to keep you as well informed as possible in all aspects of your care. We may not always do this to your satisfaction. If we do not, speak up! - ask questions - and we will try to answer them. Good health care is possible only if you and your doctor clearly understand all your problems and work together toward their solutions.

You will be given a questionnaire as you leave. Please fill it out (your name is not necessary) so that we may know what you think of your clinic and how we can improve it.

CHARGES

Adults - First visit	$15.00
Children - First visit	10.00
Other visits	7.00
Urinalysis and hematocrit	1.00
Electrocardiogram	5.00
Hospital visits	7.00
Medications	according to type and amount
Laboratory tests	according to type and number

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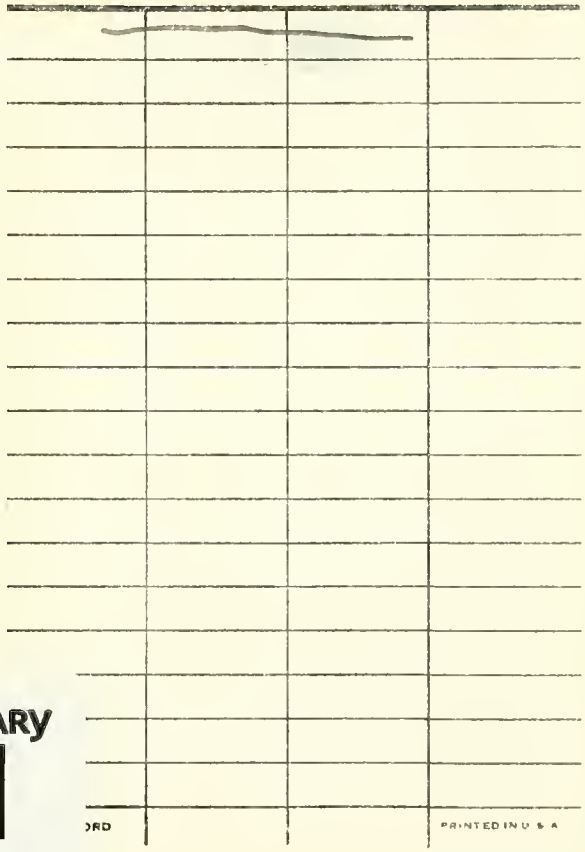

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